ACTIVITIES OF THE VA OFFICE OF INSPECTOR GENERAL

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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ACTIVITIES OF THE VA OFFICE OF INSPECTOR GENERAL

Thursday, October 8, 1987

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice at 9 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans and Stump.

Staff present: Michael Durishin and Rufus Wilson

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. This hearing will come to order. I want to thank you all for joining us. We have a tradition of trying to begin our hearings on time.

The subject of our hearing today is the Veterans' Administration Office of Inspector General. Congress recently enacted new, constitutional legislation to attack the budget deficit. Under this measure, if the deficit isn't reduced and eliminated on schedule, spending will be automatically cut. As a result, many important programs may face the threat of reduction or elimination in the future.

Can these automatic cuts in the future be avoided? No one really knows for sure, but we do know that the threat of automatic cuts can be reduced by preventing and detecting waste, fraud, abuse, and mismanagement, and also increasing economy and efficiency in government.

Created by Congress to be an independent and objective unit, the Office of the Inspector General plays a major role in these efforts. By statute, the goals of this office include: promoting economy, efficiency and effectiveness in the operation and administration of programs; preventing and detecting fraud and abuse; fully informing Congress and the Administrator of problems and deficiencies which are identified; providing leadership; and, conducting and supervising audits and investigations.

This committee believes it is essential to constantly safeguard the integrity of the beneficial programs which a grateful Congress has enacted. This committee also believes program reviews must never undermine the ability to provide those earned benefits to intended beneficiaries, and in the beneficial manner the law intends.

The VA Inspector General has the authority to inquire into all Veterans' Administration programs and activities. The annual budget of this office is more than $18 million and the staff of the IG exceeds 380 employees.

Are these resources and authority being used wisely and efficiently? Are they adequate to the task when compared to the importance, size, and scope of the Veterans' Administration? We want to hear, from the Inspector General, if there are any recommended adjustments.

Audits and investigations are the activities most often associated with the Office of the Inspector General. During one recent 6 month period, the VA Office of Inspector General reported issuing 116 audits and opening nearly 600 investigation cases. We want to review the various types of audits and investigations conducted by the IG and the results which are achieved.

As we review the objectives, the organization and operations of the Office of the IG today, we want to examine the full record. We want to identify accomplishments and achievements as well as any obstacle which could lessen the effectiveness of this important office.

Before calling our first witness today, I want to recognize Bob Stump, the ranking minority member of our subcommittee, for any statement or comments he wishes to make at this time.

[The prepared statement of Chairman Evans appears on p. 23.]

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman. We certainly commend Mr. Sato and his staff for the job they're achieving for the veterans and American taxpayers, and for the savings. For promoting the cost-effective and efficient provision of veterans services and benefits is indeed a critically needed function. The desire to economize and save money by attacking fraud, waste, and abuse should not be translated into an objective to reduce the total outlays of the Veterans' Administration. The objective should be to free inefficiently spent funds and resources for expenditures in other areas of need within the Veterans' Administration budget.

I am pleased to see in your statement that you are shifting the focus of your efforts in the present construction area from requirements justification to overall management of the construction contract administration process.

Cancellation of a medically needed facility is a denial of entitlement, not cost-effective waste reduction.

The job of avoiding fraud, waste, and abuse is tough enough without adding a review of medical needs and conclusions for such facilities. Thank you.

Mr. EVANS. Thank you.

We are happy to welcome Frank Sato, the Veterans' Administration Inspector General, to the subcommittee today. Mr. Sato has served as Inspector General of the VA since his confirmation by the Senate in 1981. Slightly more than 5 years ago, in June 1982, he made his first formal appearance as the VA Inspector General before the Oversight and Investigations Subcommittee. Prior to his

appointment as the VA Inspector General, he served as the first Inspector General of the Department of Transportation.

Accompanying Mr. Sato today are Mr. Renald Morani, the Deputy Inspector General; Mr. Robert Hincken, Assistant Inspector General for Investigations; Mr. Ken Furukawa, Assistant Inspector General for Audit; and Mr. Jack Kroll, Assistant Inspector General for Policy, Planning and Resources.

I want to welcome Ken Furukawa back to the committee. Ken testified before our subcommittee in late July when we examined the issue of contract medical services. Ken made an important contribution to that hearing which we greatly appreciate.

I also want to acknowledge Bob Hincken who has recieved the Law Enforcement Leadership Award for 1986 presented by the Association of Federal Investigators. Please accept our congratulations on your fine efforts and this important recognition, Bob.

Before you begin your testimony, Mr. Sato, I would like to emphasize a few facts about the size and importance of the Veterans' Administration and the scope of your activities.

Our veterans population is 27.6 million. Veterans, their dependents and survivors of deceased veterans number 79 million people, or almost one-third of our Nation's population. The $26.5 billion budget of the VA was the fifth largest among all Federal departments and agencies in fiscal year 1986. More than 253,000 men and women are employed by the VA to provide benefits and services to this Nation's veterans, their dependents and survivors. The VA administers the largest medical care system in the free world today, providing medical, surgical, dental, and outpatient care through 172 hospitals and 229 outpatient clinics. Nearly 3 million veterans receive disability compensation with a value of $10 billion per year, and more than 1 million widows and other survivors of veterans receive survivor compensation or death pension benefits.

In addition to the responsibilities of the IG which I previously mentioned, the IG also has responsibility for reviewing proposed and existing legislation and regulations, overseeing Veterans' Administration security procedures; participating in the President's Council on Integrity and Efficiency; and, processing requests under the Freedom of Information and Privacy Acts.

With that further description, we're ready for your testimony, Mr. Sato. Without objection your prepared statement will be entered into the record, and you may proceed in any manner you would like at this time.

STATEMENT OF FRANK S. SATO, INSPECTOR GENERAL, VETERANS ADMINISTRATION; ACCOMPANIED BY: RENALD P. MORANI, DEPUTY INSPECTOR GENERAL; ROBERT A. HINCKEN, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS; KENNETH T. FURUKAWA, ASSISTANT INSPECTOR GENERAL FOR AUDIT; AND, JACK H. KROLL, ASSISTANT INSPECTOR GENERAL FOR POLICY, PLANNING AND RESOURCES

Mr. SATO. Thank you very much, Mr. Chairman and Members of the Subcommittee. I do appreciate very much the opportunity to appear before you today to review the activities and accomplishments of the Office of the Inspector General. I would like to make

a brief statement before we proceed, and I appreciate having my statement entered into the record.

Your invitation to me, Mr. Chairman, stated the purpose of the hearing was to review the objectives, organization, operations, and accomplishments of the VA Office of the Inspector General. Public Law 95-452, The Inspector General Act of 1978, created independent and objective units to conduct and supervise audits and investigations; provide leadership and coordination, and recommend policies for activities designed to promote economy, efficiency, effectiveness of operations; prevent and detect fraud and abuse;, and to keep the Administrator and the Congress currently and fully informed. I believe that these mandated objectives have been fully implemented.

Organizationally, we have established a centralized operation where policy direction is maintained at the Assistant Inspector General level and implementation of these policies is carried out by operational headquarters divisions and regional offices. This alignment, a copy of which is included in my statement, provides a clear division of authority and responsibility, promotes cooperative efforts between our audit and investigative reviews, and permits a flow of communication throughout the organization.

To keep pace with management priorities and to improve operations, we've implemented a number of organizational and personnel changes since 1981. From an organizational viewpoint, the most significant changes have been to increase the number of regional offices from four to eight, to collocate our auditors and investigators, change the focus of the headquarters audit and investigative offices from primarily staff responsibilities to operational audit and investigative responsibilities, and to establish an enhanced ADP division providing automatic data processing audit service, technical automatic data processing support, and developing advanced methods for using ADP in audit and investigative work.

The current staff consists of professional auditors, analysts, and criminal investigators capable of fully implementing our responsibilities under the Inspector General Act of 1978. We are currently authorized a staffing level of 381 personnel, and our funding level for fiscal year 1988 is $20.4 million. Our centralized administrative alignment permits us to maximize the number of personnel assigned to operational audit, investigative and related activities. Currently we have 345 of the authorized 381 level assigned to operational-type positions, with the remaining 36 positions assigned to support positions.

The Assistant Inspector General for Auditing is responsible for planning and performing audits of VA programs and operations, with audit coverage directed toward identifying opportunities for improved economy and efficiency in operations, and for better internal controls to help ensure the integrity of VA programs and operations. Audit coverage of VA programs and activities is accomplished through a series of cyclical audits, currently every 3 years, and through coordinated VA-wide audits of major programs and functions.

Our cyclical audits concentrate on the effectiveness of internal controls and economy and efficiency of operations and programs at a particular site, whereas our VA-wide audits assess the effective-

ness of actions taken to implement programs and functions throughout the agencies medical and benefit programs.

On the investigative side, the Assistant Inspector General for Investigations is responsible for all investigations of fraudulent or serious administrative irregularities arising in VA programs and operations. Criminal matters investigated are referred to the Department of Justice for prosecution and, if necessary, subsequently referred to the agency for appropriate administrative action. Investigative operations are based on referrals, or what we refer to as reactive investigations of suspected wrong-doing. Independent probes, or what we refer to as proactive investigations are self-initiated investigations of areas vulnerable to fraud.

The Assistant Inspector General for Policy, Planning and Resources is responsible for a host of operational and support activities. Operational activities include conducting oversight and reviews of the VA Medical Inspector's office, review and investigation of VA Hotline complaints, monitoring the external pre- and post-award contract and grant audit program and operation of the information security office. He also has staff responsibilities which relate to such issues as planning, policy development, legislative review, freedom of information act releases, General Accounting Office liaison, and resource management functions.

During the 6 year period from fiscal year 1981 to 1986, the Office of the Inspector General issued over 2,200 audit reports and opened almost 6,000 investigative cases. During this period, we reported about $3.4 billion in potential monetary benefits. The investigative work during this period resulted in over 1,800 prosecutive actions and administrative sanctions. In addition, much of our work is geared toward strengthening internal controls and improving program integrity for which the results are not quantifiable in dollar terms.

I believe that the ultimate measurement of the effectiveness of our work is the action taken by management in response to our reports. The Office of the Inspector General reports can serve as a catalyst for change, but program implementation and change must be carried out by agency management who ensures that action is taken. The Office of Inspector General follows up on each of its cyclical audits during the next cyclical audit at that facility. Also, we perform follow-up audits of program areas where significant reports have been issued.

In summary, during my 6 years as the VA Inspector General, it has been my policy to work very closely with agency management to further our mutual goal of providing quality care and service to all eligible veterans and their beneficiaries. We fully expect that our program of independent audits and investigations will continue to assist the agency in meeting commitments to our Nation's veterans.

Mr. Chairman, this concludes my testimony, and my colleagues and I would be pleased to respond to any questions that you may have.

[The prepared statement of Mr. Sato appears on p. 28.]

Mr. EVANS. Thank you. My first question is a general question. Every 6 months the VA IG issues a semiannual report. In the very first report issued on April 30, 1979, there were two questions:

what is the extent of fraud, waste, and mismanagement in VA programs, activities and functions and, what has been done, particularly by the IG, and what additional steps can be taken to prevent and detect such fraud, waste, and mismanagement. How would you respond to those same questions today about the state of the VA and response capability to respond to problems within the agency?

Mr. SATO. Over the years, since the Office of Inspector General was first set up, there's been a series of actions taken over time to effectively respond to the mandate of the act. First of all, on the investigative side, our staff was initially directed primarily to administrative types of irregularities and not specifically to investigations of criminal fraud. Bob Hincken and his staff have worked very vigorously in this area. We've improved our training for investigators, recruited some top flight people, and I think the results show good progressin this area. On the audit side we've tried to recruit people that can respond to the charge as laid out in the Inspector General Act. We've also had a stronger training program. We've addressed the issue of automatic data processing by using modern technology to respond more efficiently to our own work as well as to issues within the agency. The issue of fraud and waste within the agency is also something that's a continual concern to us and has been incorporated into our planning and programming function.

Mr. EVANS. In 1980, the Chief Medical Director established the Office of the Medical Inspector to conduct quality of care inquiries. Please describe the relationship between the Medical Inspector and the IG and the responsibility of the IG for medical quality assurance.

Mr. SATO. The 1980 arrangement was set up with the quality of care program responsibilities vested with the Medical Inspector under the Department of Medicine and Surgery. Within the Office of Inspector General, we have a continuing oversight responsibility, and if it's necessary for us to look into specific investigative matters, we do so. We currently have a small staff dedicated to continually working with the Medical Inspector, reviewing incident reports, and reviewing activities of that office. Our responsibility is to provide the monitorship and oversight of the quality assurance activities of the Department of Medicine and Surgery.

Mr. EVANS. Does your office have authority to hire or obtain the services of medical professionals by contract, and how many times has such authority been used?

Mr. SATO. We do have authority under the law to hire any specialist including medical personnel. To date, we have not found the need to hire doctors or other medical specialists in that whenever it's been necessary, we have obtained the services of medical personnel within the VA or within our inspector general community or within other Federal Government departments.

Mr. EVANS. By inspector general community, do you mean other Inspectors Generals offices?

Mr. SATO. In one case, we had requested assistance from the Department of Defense. We've also used personnel from the Department of Health and Human Services including personel from the National Institutes of Health and also had the help of personnel from the General Accounting Office. Except for those personnel, we

normally obtain help from VA personnel in the Department of Medicine and Surgery.

Mr. EVANS. Audit findings alone don't guarantee efficiency and economy automatically. Action by management really is needed to realize savings. You recognized this in your statement when you said the ultimate measure of the effectiveness of your work is the action taken by management in response to your reports. How do you rate VA management on implementing IG audit recommendations, and how responsive really is the VA to IG reports?

Mr. SATO. I believe that from the Administrator right on down, the tone has been set to maximize follow-up and implementation actions in response to our audit reports. We don't, of course, have 100 percent implementation on all the issues, and there are, I think, very valid reasons for that. For example, we might have agreement on a proposed recommendation that we've made—however, in the process of implementing change through a revision in policy directives or clearances through the Office of Management and Budget, there may be other considerations that might come in the picture which would defer action. Generally speaking, I think that the implementation actions have been very good.

Mr. EVANS. One follow-up question before I yield to the gentleman from Arizona. You reported about $3.4 billion dollars in potential monetary benefits for the period fiscal year 1981 through 1986 as a result of IG activities. How much of this $3.4 billion dollars has actually been realized or achieved?

Mr. SATO. That, Mr. Chairman, is a hard question to answer in that I think I should back up and explain what those figures mean. We have, under our current reporting criteria, two fundamental categories. The first is potential cost recoveries coverage and the second concerns potential cost efficiencies. Basically, what we are trying to do is to report the dollar impact of a condition. That is, we're saying that condition such and such exists, and if you were to revise the policy or correct the condition, the future potential benefit may be of a certain dollar magnitude. This responds to a basic question that is frequently asked—what's the effect of this particular issue or condition? We respond by quantifying the monetary results. There are both dollar recoveries and cost efficiencies involved.

Mr. EVANS. Is there any way to determine exactly which potential cost recoveries that might have been implemented as a result of IG investigations, audits, and other activities, and any changes in the efficiency of the organization since those dates, since basically fiscal year 1981? Could you quantify the financial success of your efforts? If not, it may be useful if it could be compiled for the record and you could submit that to us.

Mr. SATO. I would like to submit further details, but let me say, Mr. Chairman, that there are specific recovery items established as accounts receivable by our VA controller. They are tracked for collection, or there might be cases where waivers and compromises are involved. In other cases there are offsets against running awards. For example, if we were to identify an account receivable because of an overpayment, there might be a running award which would result in an offset. In another case, you may have an account receivable which is offset against current wages if they in-

volve employees, so there are various ways that the actual collection is affected.

Insofar as impact, I think there are a number of ways that our audits have impacted on the system; some have monetary implications, others have policy implications. As you know, we earlier had done a review of the medical malpractice claims area which impacts on quality of care. We recommended that mechanisms be developed for following up on misadventures or incident reported to the Medical Inspector.

We have other cases in the medical licensing area where we have done a computer match of licenses and, as a result, the whole process of monitorship of licensing has been revised. There are a number of cases where there have been basic revisions in the current policies or procedures as a result of our work and we can provide further details for you.

[The information follows:]

FINANCIAL SUCCESS OF OFFICE OF INSPECTOR GENERAL WORK

In accordance with the President's Council on Integrity and Efficiency reporting criteria used by all Inspectors General, the VA Office of Inspector General categorizes the financial results of its work as potential cost recoveries and potential cost efficiencies. These two categories of reporting the dollar impact of the Inspectors General work are intended to illustrate in general terms the cost recoveries or efficiencies that could potentially be achieved with full implementation of the Inspectors General recommendations.

At the present time, there is no system or requirements for such a system to finitely track the total financial success of our efforts. The only areas where some financial tracking occurs is for our work that leads directly to the establishment of individual accounts receivable; the establishment of fines, and penalties and settlements; and the recovery of contractor overcharges. For example, during the past 6 months $5.5 million in audit related receivables were reported, $3.1 million in fines, penalties and settlements resulted from our investigative work, and about $220,000 was collected in contractor overcharges.

The majority of reported potential cost recoveries, however, are attributable to the identification of program and system-wide weaknesses, rather than specific case identification. In such instances it is managements responsibility to initiate action to identify individual overpayments and effect billings and collections where appropriate.

The largest category of monetary benefits reported is potential cost efficiencies. This includes a wide variety of potential benefits ranging from future cost avoidances to a better use of current funds to achieve program objectives. For the most part, cost efficiencies do not mean potential reductions in outlays, but deal with more efficient and effective use of available funds. For example, in FY 1987 we projected about $782 million in potential cost efficiencies based on managements agreement to implement recommendations.

We believe that agency actions in response to our recommendations and reviews have had substantial impact on improving the effectiveness, efficiency and integrity of VA operations. I noted some medical quality assurance issues during my testimony as examples of our positive impact on quality of care. Some other areas where our audits and investigations have had monetary and policy impacts have included:

—Improved debt management and collection activities, including identification of persons with ability to pay, collection of interest, offsets against other income sources, and prompt identification, notification and follow up on debt cases.

—Improved management practices to assure veterans are provided the appropriate level of care such as outpatient, rather than inpatient, treatment where applicable

—Numerous findings and recommendations related to construction plans and justification contributed to improved agency review and revalidation procedures that should provide for more efficient and effective use of annual VA construction funds.

-Computer matching of State wage files against VA records in six states identified over $33 million in overpayments to about 5,300 veterans and dependents. The agen-

cy's agreement to assume responsibility for such matches should improve program controls and provide for continued and timely identification of erroneous payments.

Mr. EVANS. In calculating the $3 4 billion potential monetary benefits, is it possible that the same findings could be recorded in two or more consecutive cyclical audits because the recommendations in the first audit weren't implemented?

Mr. SATO. Normally that would not be the case, sir.

Mr. EVANS. Is it possible that could be the case, though, in any instance?

Mr. SATO. It might be from a facility audit as against a VA-wide audit. On a siginificant repeat finding, there may be duplications, yes.

Mr. EVANS. In 1983, on a facility audit, if there were savings that could have been realized and they are being reported again in 1986, that's effectively double reporting of those savings in calculating that figure?

Mr. SATO. Let me back up a bit. We don't like to refer to those as savings, per se, we refer to them as potential cost efficiencies in that we're trying to demonstrate what the monetary impact may be where there is a dollar relationship to a particular program or operation.

Mr. EVANS. It's potential economic benefit, potential monetary benefit.

Mr. SATO. Yes.

Mr. EVANS. Let me yield to the gentleman from Arizona. I'd like to ask more questions later.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. Sato, we appreciate your appearance here today and your statement. I wonder if you'd elaborate a little more on the President's Council on Integrity and Efficiency, and especially elaborate on the statement again where you say, in accordance with the criteria, this savings came about. What are those criteria.

Mr. SATO. I'm sorry?

Mr. STUMP. On page 4 in your statement, you said in accordance with the criteria established by the President's council, $3.4 billion was saved or benefitted or whatever term you used. What was that criteria?

Mr. SATO. Basically there are two criteria which have been established through the President's Council, and this is strictly for definition and consistency of reporting between the various IGs. Potential cost recovery is defined as a commitment by program management to review an issue for validity of a debt and if found to be an actual debt, to establish an account receivable. In other words, this focuses on potential dollar recoveries, as against the second area which we refer to as potential cost efficiencies. These are the avoidance of spending monies on unjustified projects or functions or programs, or better utilization of funds through the identification of deficiencies in operations. Those definitions were established by the President's Council so that we might have consistent reporting of terms between the IGs and in the IG's summary report to the President.

Mr. STUMP. Your auditors make recommendations for improvements in service and obtain concurrence from hospital directors.

What follow-up occurs by your office to make sure these take place, that that savings is there?

Mr. SATO. In our next cycle audit, we have a requirement that all prior recommendations are reviewed. They are referred to in the report specifically in the scope section, and if there is a repeat item which has not been corrected, we would identify it. I might add that the Administrator particularly wants to know where a recommendation which has been made in a prior audit and agreed to by management has not been effectively implemented. On the major ones, I discuss them personally with the Administrator.

Mr. STUMP. Your Department of Medicine and Surgery audits sometimes suggests that length of stay in hospitals can be reduced. How are your auditors qualified to do this; aren't those mecical decisions, rather than a decision by an auditor, that those lengths of stays can be reduced and should be reduced?

Mr. SATO. Our review in that area looks at medical records to determine whether or not a patient might be discharged. For example, in the medical record we may find a statement by the doctor saying that a patient may be released but, because of other administrative reasons the patient was not actually released. This type of case is reviewed by our auditors with the chiefs of the various medical services. We do confer with the medical personnel at the station or with the Medical Inspector, as the case might be, to review this type of case. It's not a function that we do unilaterally.

Mr. STUMP. Thank you.

Mr. EVANS. In those audits, have you ever reported a failure of an installation to treat veterans who are entitled to care? Have you ever reported the premature discharge of a veteran?

Mr. SATO. I'm not aware of any instances. Let me ask my colleagues. I don't believe we've noted any.

Mr. EVANS. Sometimes we get so consumed in trying to obtain cost savings that we overlook the fact that the IG also is there to help veterans who have problems in the way that they're treated, particularly if there's a systematic problem. If you're looking into problems of keeping veterans in the hospitals too long, perhaps there's also problems of premature discharge or failure to treat veterans in a manner that they should be treated. Any response?

Mr. SATO. Yes, we're very cognizant of that point. In fact, we have issued reports, for example in the benefits area where we've not only commented on overpayment, but underpayment of awards. So, yes, we're interested in the integrity of the system, whether payments are over or under. I'm not aware of any case where we noted any premature hospital discharges, but in the benefits area we have definitely commented on the underpayments as well as overpayments.

Mr. EVANS. Let me return to audit recommendations and how they're implemented. How do we know which audit recommendations have been fully or partially implemented by agency management and which haven't? Do you get progress reports from management on implementing these recommendations? Has management concurred with findings and then not taken action?

Mr. SATO. We have a two-fold process, Mr. Chairman. First, every report identified in our semiannual report goes through a follow-up process. The agency's follow-up official is the Deputy Ad-

ministrator. He has asked my office to provide the staff support on the follow-up function. Consequently, we track the audit recommendations included in the prior 6 months' report to final completion; Of course, we also follow-up during our next audit to make sure that those recommendations are in fact implemented or not. On the cycle audits and in the case of special programs or high priority items, we would do special follow-up audits.

Mr. EVANS. Let's say you're not satisfied with the follow-up process. You can bring up the matter in the next audit. Is that the only sanction you have, to again address that matter in the next audit of that facility or that function? Are there any other sanctions you have? If you don't and you're generally dissatisfied with their action, is there anything we might, in Congress, do to impower your office to further pursue those changes?

Mr. SATO. Under the current follow-up process where the Deputy Aministrator is designated as the agency follow-up official, my staff provides the staff support to track all of the recommendations. This is working very well. If we're not satisfied with the actions being taken, I will discuss those directly with the Deputy Administrator and, in fact, sometimes with the Administrator. This process has come about since 1981 and it's contributed tremendously, I believe, to the actions being taken by management on the various recommendations made. I think the overall process is working quite well, and certainly much better than I've ever experienced before coming into the VA in 1981.

Mr. EVANS. Is it often that you've had to go to the Deputy Administrator or to the Administrator because of a failure of management to pursue through this process, the follow-up process, the recommendations in a matter satisfactory to your office? How many occasions have required you to go and talk to the Administrator?

Mr. SATO. I don't recall the exact numbers, but it's not real frequent. I, as a matter of routine, meet with the Administrator and the Deputy Administrator once a week, and it's on these occasions that I would normally discuss issues such as this. There has not been a large number of cases like this.

Mr. EVANS. The IG periodically issues recommendations on planned construction. Has the IG examined colocation of VA regional offices on medical center grounds, and what were your findings if you have?

Mr. SATO. We have looked at that issue, but we have not had too many cases where we've had any comment on that. Let me refer that question to Mr. Furukawa.

Mr. FURUKAWA. Our emphasis in our reviews of construction projects, at least in the recent years, has not really addressed that issue, primarily because of the nature of the audits that have been scheduled. We were looking primarily at, as we pointed out earlier, the need or justification for certain projects or, perhaps, the need to reduce the scope of certain projects because changes in workload did not materialize, and things of this nature. Since that time, we have changed the focus of our audits to review more closely the adequacy of contract administration and project management and, as a result, in the last year and a half, we have not really gotten involved in that issue of colocation.

Mr. EVANS. That's been an issue of great interest on this committee and controversy between the VA and this committee. We really believe that tremendous cost savings could be realized in colocation. I pursued this by means of an oversight hearing this year and we're convinced that there are great savings that could be realized. I think it's something that perhaps you may want to take a look at.

Mr. SATO. Yes sir, we will note that in the future.

Mr. EVANS. Good, thank you. According to your testimony, the focus of your construction audit activities changed last year from assessing the need for proposed construction projects to the management of construction contract administration process. What prompted this change and what is the focus this fiscal year?

Mr. SATO. That change was really prompted by the fact that I felt that we had done substantial work in the construction requirements area. As you know, construction is a major program within the VA. For some time, we have been concerned about ongoing construction and how those projects are managed. As you know, Mr. Chairman, the matter of program management has been an area of great concern especially where there are large numbers of change orders on a project. We are currently focusing on this area as the next phase of the construction audits to be sure that the contract specifications are met and that, to the best of our ability, we manage that program effectively with minimal changes. Of course, if there are changes that are required, we want to see them implemented in a timely way.

Mr. EVANS. Was this change based on your experience? For example, a 1983 audit of the Muskogee, Oklahoma, medical center challenged the planning of a clinical addition. According to the auditors, demand for outpatient care would decline and the project should be cancelled, but, in fact, the opposite actually occurred. Outpatient visits have increased at a faster rate than the Department of Medicine and Surgery had predicted and the number of visits already this year has exceeded the projection for 1990. I wonder if there are other instances in which there have been problems with assessing the need for construction projects and this meant changing the focus to actual construction contract administration. Has that been based generally on your experience and the problems we're facing within the VA?

Mr. SATO. Our change in that area, as I mentioned earlier, was because we felt that we'd done sufficient work in the construction requirements area. If there is a difference in views or conclusions on any particular project, and I'm not familiar with the particular Muskogee project you're referring to, our staffing process would identify whether or not we have disagreements on a particular audit. If there are disagreements, they would be elevated to the next level until we could ultimately resolve it one way or the other. Most of the cases have been resolved effectively. We've tried to concentrate on the documentation and justification for the project and, in certain cases, the project may be fully justified but the documentation isn't there to really support the project. We've tried to help maintain the integrity of the VA's system, making sure that what we say is needed and that the factors used to support that project are, in fact, existant. I think that process has

worked quite well and in the last year there's been substantial change within the VA on the whole facility and construction process.

Mr. EVANS. You listed as an objective the effectiveness of agency programs and operations. You also list as an objective to keep the VA management and Congress fully informed about problems and deficiencies in VA programs and operation. Why are your reports generally in the direction economy? Let me give you an example. On page 6 you outlined areas of inquiry. Under loan guarantees, you omit loan servicing, yet this is an area the GAO reported to us as the greatest deficiency. Did you ignore that investigation because that would have disclosed that the VA needed to do more in this area?

Mr. SATO. I don't believe we've ignored the area, Mr. Chairman. In fact, in the whole loan guarantee area we've done substantial work over the past few years, both from the audit and the investigative side. We have done areas concerning foreclosures, underwriting, appraisals and refinancing—

Mr. EVANS. But the GAO noted that the loan servicing area was the greatest deficiency. What have you done specifically in that area?

Mr. SATO. We have done work in this area. For example, we issued a report recently on portfolio loans where we comment on the fact that the servicing function was not as effective as it ought to be, and we've raised some serious questions about the portfolio area. I'd like to provide further details of that audit for the record for you, sir.

[The information follows:]

AUDIT OF MANAGEMENT OF VA PORTFOLIO HOME LOANS—JULY 15, 1987

1Our audit of the VA portfolio loan program found that servicing was not typically conducted in accordance with VA policy and, as a consequence, was frequently superficial, untimely, or ineffective. The audit results showed that about 75 percent of the loans in serious default at June 30, 1986, were not serviced adequately. For example:

—in 59 percent of the cases reviewed initial contact with the borrower was not made within 30 days of the notice of default as required by existing policy, (91 days average to first contact);

—no contact was made with the borrower in 6 percent of the cases;

—initial contact consisted only of a form letter in 70 percent of the cases where an initial contact was made;

—follow-on contacts were infrequent or inconsistent averaging over 3 months between contacts;

—in 21 percent of the cases, the reason of default was never determined by the loan servicing representative;

—at June 30, 1986, the loans had been delinquent an average 19 months.

Investigative contacts with veterans and loan guaranty personnel identified two additional loan servicing problems which contribute to program losses. First, some lenders and services refuse to accept partial payments to borrowers. Such policies reflect a reluctance to accept repayment plans and can force loans to foreclosure which might otherwise have a chance for cure. It can also result in higher claims payments for VA. Second, review of lender servicing records by VA Loan Guaranty staff has identified instances where lenders have falsified servicing records to indicate compliance with VA requirmentts.

These findings reflect the need to improve the timeliness and effectiveness of loan servicing. We have concluded that existing policy is appropriate and adequate to achieve desired results. Recommendations were made to: (1) enhance management oversight to ensure that lenders and VA field staff service loans promptly in accordance with established policy; (2) ensure personal contact is made with borrowers to

determine the reasons for default, likelihood of cure, and potential for repayment schedules to bring the loan current; and (3) identify incurable loans for prompt termination. The Chief Benefits Director agreed with recomendations for improvement and provided aceptable implementation plans.

Mr. EVANS. We certainly would like that. Portfolio loans really aren't loans directly to the veterans and that's the area that we're concerned about. Particularly GAO is concerned about it's recommendation that this is the greatest deficiency. So, it's an area that you should maybe spend some resources and some time looking into.

Mr. SATO. Yes, we certainly will, sir.

Mr. EVANS. In compensation and pension benefits, you list benefit overpayments. In my own experience, complaints of underpayments really far exceed overpayments, and I'm unaware of any report in which you document failure to grant benefits to which a veteran is entitled. Have you ever done so since you've been the Inspector General?

Mr. SATO. Yes, earlier we issued a report which concerned statistical quality control and in that report we noted cases where there were both overpayments as well as underpayments due to the weaknesses in the quality control process. Again, I would be happy to provide for the record details of that particular project.

[The information follows:]

AUDIT OF DEPARTMENT OF VETERANS BENEFITS STATISTICAL QUALITY CONTROL FOR BENEIFTS AUTHORIZATION—JULY 15, 1982

The Office of Inspector General, with the cooperation and assistance of the Department of Veterans Benefits (DVB), audited the Department's Statistical Quality Control (SQC) review process. SQC is the primary quality measurement and evaluation mechanism DVB uses to evaluate compensation, pension, and education payments to beneficiaries. The audit evaluated the effectiveness of the SQC review process in determining the accuracy of benefits payments. In Fiscal Year 1981, the VA paid about $14.6 billion in compensation, pension, and education benefits to 5.8 million beneficiaries.

Our audit found that the SQC system was not efffective in measuring the actual levels of quality in benefits authorizations. Our review of a nationwide sample of 4,428 authorizations disclosed substantive (payment or entitlement) error rates of 8.6 percent for education and 5.4 percent for compensation and pension actions. These error rates did not meet established quality standards and were 2 to 3 times the rates reported by regional offices.

We projected that actual uncorrected erroneous payments to beneficiaries totaled approximately $79 million in Fiscal Year 1981. The erroneous payments included $48 million in overpayments and $31 in underpayments for a net loss of $17 million to the Agency in Fiscal Year 1981. In addition, judgement errors, where the evidence of record did not sustain the authorized level of payments, accounted for unsupported payments of approximately $183 million. This included possible overpayments of $171 million and $12 million in possible underpayments. This audit reported approximately $43 million in total underpayments to VA beneficiaries.

Mr. EVANS. Again, I want to state that you do well in trying to point out the potential cost efficiencies within the system and the monetary benefits, but I'm worried if that's not practically the sole concern of your office; trying to basically eliminate the waste, fraud, and mismanagement without any concern about helping the veterans who are having some problems, either in DM&S or in the compensation benefit area obtain the benefits to which they're entitled. We'll hear from one of our veterans representatives that they have some concerns in this area, as well.

Mr. SATO. I think that there are a number of areas where we've tried to help the veteran. Our work in the mobile home area is a classic example where it's resulted in direct benefit to the veterans who have been ripped off, so to speak. Let me ask Mr. Hincken to expand on that.

Mr. HINCKEN. Yes, sir. The mobile home area, at this point, we've collected about $2.1 million with several hundred thousand in process. All of that money is returned to the VA revolving fund, and portions of that money is also used to offset some veterans' debts that have been involved in a foreclosure.

Mr. EVANS. My experience with the IG, when I was in the service, was that the IG was somebody you could call if you had a problem. Being an enlisted man, the IG was kind of your last, best hope. Noting the semiannual report dated September 30, 1986, and the Hotline promotion, it is more than just an employee hotline, it's open to the general public?

Mr. SATO. Yes, sir.

Mr. EVANS. It's a good program, but, all you ask is: are you aware of fraud, waste, and mismanagement, call the hotline. That's good and I think you're doing good work in that area, but I'm concerned that maybe even in the promotion of your hotline, and in the focus of your office, you're not giving enough focus or concern to helping veterans. Obviously, we've got budgetary problems, but if you're not even advertising that your office is available to do anything more than cut programs, I'm concerned that you're not getting the message out there that you're also there to help veterans when they're not getting the veterans' benefits they deserve.

Mr. KROLL. Mr. Chairman, the hotline is my responsibility, and I can assure you the message is out. We receive literally hundreds of letters or calls a month from veterans with various problems with the VA and we do make a conscious effort to follow up on each one of those with DM&S or DVB. Whatever the case might be we do try to get his issue resolved.

Mr. EVANS. I would like to see that emphasized in your future advertisements.

Mr. KROLL. Right, the advertising may not be directed that way, but the word is out, through the service organizations and through our phone contacts.

Mr. SATO. And, we will take another look at that and see whether we can take care of the concerns that you raised, Mr. Chairman.

Mr. EVANS. I would appreciate that. Thank you.

On page 7 of your statement you listed unemployability as an area of investigation. It's my understanding that this committee asked the VA to review individual unemployability because thousands of psychiatric claims were rated as unemployable when they should have been 100 percent under the ratings schedule. Now I'm told that largely through your efforts, grants of individual unemployability are virtually non-existent. I view that as unwarranted intrusion in the policy-making area. Another example, 38 CFR 3.204 reflected the VA's beneficial approach to the requirement of proof of relationship. I'm told that due to IG insistence, a much more restrictive rule is about to be promulgated. Isn't this departure from the beneficial intent of veterans' legislation another unwarranted intrusion in the area of policy making?

Mr. SATO. First of all, as far as the policy making is concerned, Mr. Chairman, my role is strictly advisory in nature and we make recommendations for change if it's appropriate. But, in unemployability-type cases, the basic thrust of our work has been computer matches of 100 percent unemployability types of awards. The VA has made that type of award and our computer match would show that the individual is gainfully employed. There is a disparity between the indication by the veteran that he or she cannot work and the fact that they are, in fact, employed. We have asked the VA to review those kinds of cases, and whatever policy changes are made are the responsibility of program management, not my office.

I'm not familiar with the later issue that you mentioned. Bob, have you—

Mr. EVANS. Could you review it and report back to us? We'll submit that question to you again.

Mr. SATO. Yes. I'm not familiar with that issue at all, and I'm not sure whether we've been directly involved in that second issue.

Mr. EVANS. I'm concerned about a problem the VFW has alleged in their statement which they'll present shortly. With regard to computer matching to detect overpayments and instances of fraud in VA compensation and pension program, the VFW questions whether it would be wise and compassionate to apply state-of-the-art investigative techniques to the large contractors and suppliers with which the VA does business, rather than to disabled veterans and their widows and dependents. They say even if the $20.5 million in overpayments reported by the DVB regional staff is accurate, the VFW sincerely doubts that the VA will be able to recover a small percentage of that figure. They go on to say, in fact we cannot help but wonder if enough will be recouped even to pay for this type of high-tech investigation. Any comment about those concerns?

Mr. SATO. Yes. First of all, computer matching is one of several techniques we have in our audit and investigative process. Our compensation and pension program lends itself very well to the computer matching process in that you're talking about large volumes of data. We can simply take the compensation and pension files and, by the use of the computer, compare it with wage data that the states have maintained. It's a simple process for us, and once we get a match, we can do some further analyses and referrals through the appropriate regional office to determine whether or not we have misinformation being reported insofar as wage and earnings are concerned on the annual income-type questionnaires. That process does not lend itself to reviews of contractors' rcords, in that contractors' cost records are a specific and unique type of a record documenting what we have contracted for.

Now, the second part of your question regarding how much has been collected; I believe that as a result of our matching effort, there's been over $33 million so far identified as overpayments in this area. And, in fiscal 1986, alone, there was over $2.4 million actually collected. There is much more in terms of offsets against running awards or future reductions in awards granted, as the case might be. There might be waivers and compromises affected because of unusual circumstances or, in other cases, when the cases

come before the courts, you may have court-ordered restitutions which might be a lesser amount than the actual overpayment.

So, there's a series of conditions that would affect that $33 million over payment and future payments which might have continued had not the particular case been identified.

Mr. EVANS. Is there any cost benefit analysis for computer matching that you have within the IG?

Mr. SATO. Yes, sir.

Mr. EVANS. Could we have that submitted for the record?

Mr. SATO. Yes, sir.

[The information follows:]

COST BENEFIT OF VA OFFICE OF INSPECTOR GENERAL COMPUTER MATCHES

Computer matching, the comparison of VA data bases with data bases of other activities, has proven to be one of the most effective methods of carrying out our audit and investigative responsibilities. Computer matching permits the OIG to review and analyze large automated data bases that would be impractical to review on a manual basis. These reviews have proven to be both cost beneficial and beneficial in terms of identifying internal control weaknesses in VA programs.

To date, we have expended approximately $1.4 million to identify approximately $40 million in overpayments and have achieved about $3.3 million in repayments. The overall ratio of costs incurred to overpayments identified is 1:28.6 and of costs incurred to repayments made is 1:2.3

Because of the effectiveness of computer matching, the Department of Veterans Benefits has agreed to incorporate this technique in its system of internal controls for verifying the accuracy of pension and certain compensation payments. Our computer matches in the Department of Medicine and Surgery have also had a positive impact on program controls. For instance, our computer matches in the area of professional licensure of physicians and nurses have resulted in a complete rewrite of employment applications to identify all disciplinary actions, established a new control to require periodic matching with licensing agencies and helped support legislation to require the VA to periodically check on health care licenses.

Mr. EVANS. Two other areas of concern. The new fiscal year is just one week old. What are your priorities, goals, and objectives for this new fiscal year, generally?

Mr. SATO. Our goals and objectives are pretty much the same. We have a whole series of areas that we have identified. We're looking at program controls; internal control weaknesses that might have been identified through our process; the medical program, because it is one of the largest areas; and, of course, the benefit programs. We continually look at benefit payments because the vulnerability in those areas are the greatest. As you know, there's been reductions of staff within the Department of Veteran Benefits which also doesn't enable the VA offices responsible for the program to monitor all the various aspects as well as they would like.

I would like to provide for you for the record all of the areas in the 1988 program. We haven't solidified all those plans yet and we're in the process of doing so right now.

Mr. EVANS. That would be fine. If you're using a calendar year basis, that's fine too; whatever your plans are.

Mr. SATO. Yes, sir.

[The information follows:]

AREAS IN THE OFFICE OF INSPECTOR GENERAL'S FY 1988 PROGRAM

The Office of Inspector General has developed a set of strategic planning issues that are intended to provide broad policy and program direction in formulating plans for audits and investigations. In FY 1988, we are focusing on the following five key program areas:

—Patient Care: concentrating on quality assurance and patient management
—Support Functions: such as procurement and automated data processing (ADP)
—Financial Management, debt collection, financial reporting
—Construction contract administration
—Benefit Programs: especially loan guaranty and compensation and pension authorizations

These issue areas will receive emphasis during our cyclical audits of VA facilities. Currently, about 80 facilities are scheduled for audit in FY 1988 as part of our program of 3-year cyclical coverage of VA facilities.

In addition, these issue areas will also be the focus of attention for our program-type audits and proactive investigations. During FY 1988, we plan to spend about 13,600 staff days for program audits and proactive investigative reviews. Some of these audits and reviews on-going or in the planning stage are:

—Cost recovery from health plans
—Mortgage lending practices
—VA fiduciary activities
—Procurement practices
—Contract extensions of veterans in community nursing homes
—Outpatient workload reporting
—Administration of construction contracts

Mr. EVANS. Earlier this year I contacted your office about serious allegations concerning the VA medical center in Cincinnati. Can you tell us the current status of this investigation?

Mr. SATO. Yes, sir. That particular case is still continuing. As you know, earlier, the FBI had completed a criminal civil rights investigation. The results of that investigation were inconclusive in that the Department of Justice declined to prosecute. Once the FBI completed their work, the Office of Special Counsel, under the Merit System Protection Board, began their investigation concerning the reprisal issue. We are currently awaiting the Office of the Special Counsel's report. I had an indication that we would receive that report last month, but it apparently has been delayed in the Office of the Special Counsel. In the meanwhile, we have had a member of my staff working with the Office of the Special Counsel investigators. We have received some of the preliminary materials from that investigation, and we've been working with the agency counsel reviewing data to determine whether standards of conduct provisions have been violated. We're awaiting the final conclusions of the Office of Special Counsel before we determine whether or not additional investigation is required.

Bob, would you like to add anything to that?

Mr. HINCKEN. Mr. Sato covered it perfectly.

Mr. EVANS. I yield to the gentleman from Arizona.

Mr. STUMP. Let me follow up. I assume that you're talking about the chief of police.

Mr. SATO. Yes, sir.

Mr. STUMP. Let me ask you another question. As Inspector General, what is your role other than such matters as the killings there, etc., or do you have one?

Mr. SATO. Let me refer that to Mr. Hincken.

Mr. HINCKEN. Yes, sir, Mr. Stump. The murder of the two police officers was generally categorized as a crime on a government reservation and it was handled by the Federal Bureau of Investigation. My agents are primarily concerned with the white collar crime area.

Mr. STUMP. I have a specific case—the Harvey case.

Mr. HINCKEN. Oh, I'm sorry. In the Harvey matter, sir, the FBI is handling that investigation.

Mr. STUMP. You have no role in it?

Mr. HINCKEN. Not at this time, sir. They have not inquired nor asked our assistance.

Mr. SATO. As you know, those issues are pending before the courts currently.

Mr. STUMP. When you find cases of fraud, how do you interact with the Department of Justice?

Mr. SATO. We are in very close contact with the Department of Justice on most matters that involve the VA. So, as a result, as in the allegations regarding Chief Wilson in Cincinnati, while the investigation was conducted earlier by the FBI, we have been in contact with the FBI and we're generally aware of the investigation's results.

Mr. STUMP. In the case of fraud uncovered in construction, do you automatically or immediately contact Justice, or do you finish the investigation; how do you handle that?

Mr. HINCKEN. Generally, sir, we will initiate an investigation, as in your example in the construction area. We will probably contact a local United States Attorneys Office when there's some indication that the likelihood of the crime has been committed. We'll make an early referral and get with the prosecuting attorneys, but, we will work with them all the way through to the conclusion of the investigation.

Mr. STUMP. Thank you.

Mr. SATO. That, I might add, Mr. Chairman, is a requirement stated within the Inspector General Act, where as soon as we have any indication of criminal violations of law, we are mandated by the Act to expeditiously contact the Attorney General or his people.

Mr. STUMP. I have a couple questions I'd like to submit for the record.

Mr. EVANS. Without objection, so ordered and I also have some additional questions that I'll be submitting. Just one final follow-up question. I guess my bone of contention is with the Office of Special Counsel because this report has been delayed many months. What steps will you take, not knowing what the recommendations are, after the report is issued? What will be your next step?

Mr. SATO. Our next step would be to review the conclusions and whatever recommendations that report might contain. Our immediate concern then would be whether or not we are to conduct any further investigation regarding the allegations that have been made. We have been continually in contact with the Office of Special Counsel, and we had hoped that the report would have been released much earlier; unfortunately it's been delayed for whatever reason that I'm not familiar with, but we, too, are hopeful it would be wrapped up soon. The Administrator has asked me to call the Office of the Special Counsel several times, which I have, but that report, unfortunately, has been delayed and it's really out of our control.

Mr. EVANS. This is a matter of great interest not only to myself, but to Mr. McEwen of our larger committee and, I think, other Members of Congress. When the OSC finally does make its report,

we hope that you'll take quick, expeditious action and take the steps that you've indicated you will take.

Mr. SATO. Yes, sir. We will put top priority on that matter.

Mr. EVANS. We want to thank you. Normally we don't have this many questions for one specific panel and you held up very well. We will be submitting additional questions as Congressman Stump and I indicated. These questions and your written responses to them will also be made a part of the record. Thank you for coming today.

Mr. SATO. Thank you very much.

Mr. EVANS. Our next and final witness is Mr. Dennis Cullinan, Assistant Director of the National Legislative Service, Veterans of Foreign Wars, and I welcome him to our subcommittee. His prepared statement, which he's already submitted, without objection will be made a part of the official record. Please proceed in whatever manner you would like to, Dennis. You may summarize and we'll ask you questions when you're done.

STATEMENT OF DENNIS CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you, Mr. Chairman. I will summarize and basically extract from my written statement.

First of all, I'd like to thank you and the Members of this subcommittee for affording the Veterans of Foreign Wars this opportunity to comment on the performance and the operation of the Veterans' Administration Office of Inspector General. We wish to commend the Chairman and the Members of the subcommittee for holding this hearing so that this mechanism for preventing fraud and abuse within the VA may be improved.

For its part, the VFW strongly supports actions which will enable the VA to more efficiently and effectively utilize its resources. We well appreciate that in this time of fiscal restraint and ever-increasing pressure that only in this way will the VA be able to properly carry out its mission of serving this Nation's veterans through a scrupulous effort to operate as efficiently as possible. And, it is precisely in this area that the VA Office of Inspector General has important contributions to make.

On the other hand, it is also our concern that an exaggerated emphasis on cost avoidance and operational efficiency will result in diminishing the care and compassion provided veterans by the VA and will transform the status of veterans' entitlements and programs to that of mere ciphers in the accountant's ledger. The debt of honor this Nation owes our veterans cannot be reckoned in dollars and cents alone, nor should it be repaid within the strict parameters of monies recovered and efficiencies achieved.

One area of VFW concern is major construction projects. The VAOIG's report states that the audits for planned major construction projects resulted in recommendations for project cancellations and modifications that would reduce estimated construction cost by $101 million. Similarly, audits of minor construction projects at 20 medical facilities resulted in recommendations to cancel or reduce the scope of 81 minor construction and non-recurring maintenance

projects. Although oversight of the VA's construction programs is an important element of the Inspector General's office, we do not wish to see OIG zeal for cost effectiveness result in its overruling VA medical and construction experts with respect to the needs of the VA's physical plant or the medical services provided to veterans. In other words, we strongly oppose any OIG second-guessing of VA experts that would result in a reduced number of VA health care beds and other resources being available to this Nation's veterans.

Mr. Chairman, you've already introduced our concern with the Inspector General's computer matching program. We would have to agree that a computer doesn't lend itself to this kind of operation; it's a matter of gathering together an enormous amount of numbers and crunching through them and coming up with discrepancies. And it's for this very reason that we're concerned—it's about too simple and strikes us as being a device of convenience which lends itself to a rather remorseless and uncompassionate approach to this Nation's veterans.

With respect to the recoveries of these funds, I have recourse to a truism, I suppose, that one cannot get blood from a stone. We have veterans who have fallen upon hard times, dismally hard times, we cannot expect them to come up with these enormous sums with which they are sometimes charged as overpayments, and we strongly object any action which would encourage this course.

Another area of concern pertains to diagnostic related groups funding methodology. The VFW recognizes that improved discharge planning is the key to a hospital director's success with DRB. We also recognize that the Inspector General would perceive a fast inpatient turn around as being a perfect opportunity to save money. We cannot emphasize strongly enough that the focus on discharge must never overshadow the importance of full and complete treatment.

The foregoing concerns and observations notwithstanding, the VFW also places great value on the role the OIG is playing in affording the greatest number of veterans the best possible health care through the effective and efficient utilization of resources. Its efforts in fighting fraud in the mobile home industry is a prime example of the kind of beneficial work the VAOIG can do on behalf of veterans. Its efforts to eliminate such practices as invoice packing and undervaluing bills of sales on repossessed VA guaranteed mobile homes is very important. Additionally, the IG's efforts to investigate jointly with the FBI fraudulent activities in the real estate and home loan industries is proving valuable.

The VFW recognizes and appreciates the work of the VA Inspector General, we only ask that in the course of performing its duties, this office not deprive veterans of the concern and compassion we believe to be their due.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cullinan appears on p. 38.]

Mr. EVANS. Thank you for that statement, we appreciate your contribution. You've indicated that you support a number of the IG's activities, but you've also expressed concern about the possible impact of some activities. Is it possible that some of these activities

can actually undermine the mission of the VA and jeopardize benefits and services being provided in the beneficial manner Congress has intended them to be rendered to veterans?

Mr. CULLINAN. Yes, sir. We would very strongly concur with something that you indicated earlier that there's a deliberate, maybe an exaggerated, emphasis on cost efficiencies and saving monies and seeking out veteran culprits for that matter too—looking for veterans who are guilty of overpayments. There's too much emphasis being placed on recovering monies lost and achieving sometimes vague efficiences as opposed to seeking out ways of actually helping the VA operate more positively.

Mr. EVANS. Among the members of the VFW, is the word out about the IG being an office to which veterans can turn individually if they feel they've been deprived of benefits and your organization can turn to if you see systematic problems with the VA?

Mr. CULLINAN. I know that was indicated earlier. To my knowledge, that word is not out among my membership. That's something I'll check when I go back to my office, I'll speak to our national veterans service, but to my understanding, no.

Mr. EVANS. I thank you, and I yield to the gentleman from Arizona.

Mr. STUMP. I have no questions, Mr. Chairman. Thank you Mr. Cullinan for appearing. We do concur very strongly in your statement feeling that the Inspector General should not try to, as you put it, outguess or second guess the needs for our veterans. Thank you.

Mr. EVANS. Thank you, Dennis. This concludes our hearing today and this is the last scheduled hearing we have this year in Washington. I want to thank at this time our ranking minority member and Rufus Wilson and the minority staff for their work. I also want to thank Mike, Charley, Pam, our majority staff and Katrina Kelley of my own staff for the fine work you've done this year. I want to thank all of you for attending today. The hearing is concluded.

[Whereupon, at 10:16 a.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF

HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ON

VETERANS' ADMINISTRATION

OFFICE OF INSPECTOR GENERAL

OCTOBER 8, 1987

GOOD MORNING. THE SUBCOMMITTEE WILL COME TO ORDER. THE SUBJECT OF OUR HEARING TODAY IS THE VETERANS' ADMINISTRATION OFFICE OF INSPECTOR GENERAL.

CONGRESS RECENTLY ENACTED NEW, CONSTITUTIONAL LEGISLATION TO ATTACK THE BUDGET DEFICIT. UNDER THIS MEASURE, IF THE DEFICIT ISN'T REDUCED AND ELIMINATED ON SCHEDULE, SPENDING WILL BE CUT AUTOMATICALLY. AS A RESULT, MANY IMPORTANT PROGRAMS MAY FACE THE THREAT OF REDUCTION OR ELIMINATION IN THE FUTURE.

CAN AUTOMATIC BUDGET CUTS IN THE FUTURE BE AVOIDED? NO ONE KNOWS FOR SURE. BUT WE DO KNOW, THAT THE THREAT OF AUTOMATIC CUTS CAN BE REDUCED BY PREVENTING AND DETECTING WASTE, FRAUD, ABUSE AND MISMANAGEMENT, AND INCREASING ECONOMY AND EFFICIENCY IN GOVERNMENT.

CREATED BY CONGRESS TO BE AN INDEPENDENT AND OBJECTIVE UNIT, THE OFFICE OF THE INSPECTOR GENERAL PLAYS A MAJOR ROLE IN THESE EFFORTS. BY STATUTE, THE GOALS OF THE OFFICE INCLUDE:

PROMOTING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN THE OPERATION AND ADMINISTRATION OF PROGRAMS;

PREVENTING AND DETECTING FRAUD AND ABUSE;

FULLY INFORMING THE CONGRESS AND THE ADMINISTRATOR OF PROBLEMS AND DEFICIENCIES WHICH ARE IDENTIFIED;

PROVIDING LEADERSHIP; AND

CONDUCTING AND SUPERVISING AUDITS AND INVESTIGATIONS.

THIS COMMITTEE BELIEVES IT IS ESSENTIAL TO CONSTANTLY SAFEGUARD THE INTEGRITY OF THE BENEFICIAL PROGRAMS WHICH A GRATEFUL CONGRESS HAS ENACTED. THIS COMMITTEE ALSO BELIEVES PROGRAM REVIEWS MUST NEVER UNDERMINE THE ABILITY TO PROVIDE THOSE EARNED BENEFITS TO THE INTENDED BENEFICIARIES AND IN THE BENEFICIAL MANNER THE LAW INTENDS.

THE VA INSPECTOR GENERAL HAS AUTHORITY TO INQUIRE INTO ALL VETERANS' ADMINISTRATION PROGRAMS AND ACTIVITIES. THE ANNUAL BUDGET OF THE OFFICE OF INSPECTOR GENERAL IS MORE THAN $18 MILLION AND THE STAFF OF THE IG EXCEEDS 380 EMPLOYEES.

ARE THESE RESOURCES AND AUTHORITY BEING USED WISELY AND EFFICIENTLY? ARE THEY ADEQUATE TO THE TASK WHEN COMPARED TO THE IMPORTANCE, SIZE AND SCOPE OF THE VETERANS' ADMINISTRATION? WE WANT TO HEAR FROM THE INSPECTOR GENERAL IF THERE ARE ANY RECOMMENDED ADJUSTMENTS.

AUDITS AND INVESTIGATIONS ARE THE ACTIVITIES MOST OFTEN ASSOCIATED WITH THE OFFICE OF INSPECTOR GENERAL. DURING ONE RECENT SIX MONTH PERIOD, THE VETERANS' ADMINISTRATION OFFICE OF INSPECTOR GENERAL REPORTED ISSUING 116 AUDITS AND OPENING NEARLY 600 INVESTIGATION CASES. WE WANT TO REVIEW THE VARIOUS TYPES OF AUDITS AND INVESTIGATIONS CONDUCTED BY THE IG AND THE RESULTS WHICH ARE ACHIEVED.

AS WE REVIEW THE OBJECTIVES, ORGANIZATION, AND OPERATIONS OF THE OFFICE OF THE INSPECTOR GENERAL TODAY, WE WANT TO EXAMINE THE FULL RECORD. WE WANT TO IDENTIFY ACCOMPLISHMENTS AND ACHIEVEMENTS AS WELL AS ANY OBSTACLE WHICH COULD LESSEN THE EFFECTIVENESS OF THIS IMPORTANT OFFICE.

BEFORE CALLING OUR FIRST WITNESS, I WANT TO RECOGNIZE BOB STUMP, THE RANKING MINORITY MEMBER OF OUR SUBCOMMITTEE FOR ANY STATEMENT OR COMMENTS WHICH HE MAY WISH TO MAKE AT THIS TIME.

WE ARE HAPPY TO WELCOME FRANK SATO, THE VETERANS' ADMINISTRATION INSPECTOR GENERAL, TO THE SUBCOMMITTEE TODAY. MR. SATO HAS SERVED AS INSPECTOR GENERAL OF THE VETERANS' ADMINISTRATION SINCE HIS CONFIRMATION BY THE SENATE IN 1981. SLIGHTLY MORE THAN FIVE YEARS AGO, IN JUNE, 1982, MR. SATO MADE HIS FIRST FORMAL APPEARANCE AS VA INSPECTOR GENERAL BEFORE THE OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE. PRIOR TO HIS APPOINTMENT AS THE VA INSPECTOR GENERAL, MR. SATO SERVED AS THE FIRST INSPECTOR GENERAL OF THE DEPARTMENT OF TRANSPORTATION.

79-164 - 87 - 3

ACCOMPANYING MR. SATO THIS MORNING ARE MR. RENALD P. MORANI, THE DEPUTY INSPECTOR GENERAL, MR. ROBERT A. HINCKEN, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS, MR. KEN FURUKAWA, ASSISTANT INSPECTOR GENERAL FOR AUDIT, AND MR. JACK H. KROLL, ASSISTANT INSPECTOR GENERAL FOR POLICY, PLANNING AND RESOURCES.

I WANT TO WELCOME KEN FURUKAWA BACK TO THE COMMITTEE. KEN TESTIFIED BEFORE OUR SUBCOMMITTEE IN LATE JULY WHEN WE EXAMINED THE ISSUE OF CONTRACT MEDICAL SERVICES. KEN MADE AN IMPORTANT CONTRIBUTION TO THAT HEARING WHICH WE APPRECIATED.

I ALSO WANT TO NOTE FOR THE RECORD THAT BOB HINCKEN HAS RECEIVED THE "LAW ENFORCEMENT LEADERSHIP AWARD" FOR 1986 PRESENTED BY THE ASSOCIATION OF FEDERAL INVESTIGATORS. BOB, PLEASE ACCEPT OUR CONGRATULATIONS ON YOUR SELECTION FOR THIS IMPORTANT RECOGNITION.

BEFORE YOU BEGIN YOUR TESTIMONY, MR. SATO, I WANT TO MENTION A FEW FACTS WHICH EMPHASIZE THE SIZE AND IMPORTANCE OF THE VETERANS' ADMINISTRATION AND THE SCOPE OF YOUR ACTIVITIES.

CUR VETERAN POPULATION IS 27.6 MILLION. VETERANS, THEIR DEPENDENTS AND THE SURVIVORS OF DECEASED VETERANS NUMBER 79 MILLION PEOPLE OR ALMOST ONE-THIRD OF THE NATION'S ENTIRE POPULATION;

THE $26.5 BILLION BUDGET OF THE VA WAS FIFTH LARGEST AMONG ALL FEDERAL DEPARTMENTS AND AGENCIES IN FISCAL YEAR 1986;

MORE THAN 253,000 MEN AND WOMEN ARE EMPLOYED BY THE VA TO PROVIDE BENEFITS AND SERVICES TO THE NATION'S VETERANS, THEIR DEPENDENTS AND SURVIVORS;

THE VA ADMINISTERS THE LARGEST MEDICAL CARE SYSTEM IN THE FREE WORLD TODAY PROVIDING MEDICAL, SURGICAL, DENTAL AND OUTPATIENT CARE THROUGH 172 HOSPITALS AND 228 OUTPATIENT CLINICS.

NEARLY 3 MILLION VETERANS RECEIVE DISABILITY COMPENSATION WITH A VALUE OF $10 BILLION PER YEAR; AND

MORE THAN 1 MILLION WIDOWS AND OTHER SURVIVORS OF VETERANS RECEIVE SURVIVOR COMPENSATION OR DEATH PENSION BENEFITS.

IN ADDITION TO THE RESPONSIBILITIES OF THE INSPECTOR GENERAL WHICH I PREVIOUSLY MENTIONED, THE IG ALSO HAS RESPONSIBILITY FOR:

REVIEWING PROPOSED AND EXISTING LEGISLATION AND REGULATIONS;

OVERSEEING VETERANS' ADMINISTRATION SECURITY PROCEDURES;

PARTICIPATING IN THE PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY; AND

PROCESSING REQUESTS UNDER THE FREEDOM OF INFORMATION AND PRIVACY ACTS.

WITH THAT FURTHER DESCRIPTION, WE ARE READY FOR YOUR TESTIMONY MR. SATO. WITHOUT OBJECTION YOUR PREPARED STATEMENT WILL BE MADE A PART OF THE OFFICIAL RECORD OF THE HEARING. YOU MAY PROCEED WHENEVER YOU ARE READY.

STATEMENT OF
FRANK S. SATO
INSPECTOR GENERAL
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OCTOBER 8, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is a pleasure to be here and have the opportunity to review the activities and accomplishments of my office. The statutory Office of the Inspector General was established in the Veterans Administration (VA) in October 1978. I was appointed the VA Inspector General in July 1981 after having served as Inspector General at the Department of Transportation.

OBJECTIVES OF THE VA OFFICE OF INSPECTOR GENERAL

The objectives of our organization are to prevent and detect fraud, waste, and abuse in the expenditure of agency funds and to promote improved efficiency, economy, and effectiveness of agency programs and operations. These objectives are accomplished through a wide range of audits, investigations, and other activities.

Another important objective is to keep VA management and Congress fully informed about problems and deficiencies in VA programs and operations and the necessity and status of corrective action. We accomplish this objective through our daily contacts with VA management, the issuance of audit and investigative reports, issuance of management advisory letters and opinions, and by publishing the semiannual report, which summarizes for VA management, the Congress, and the public, our operational results for each 6-month period.

ORGANIZATION OF THE VA OFFICE OF INSPECTOR GENERAL

During the period 1981 to 1987, the OIG organization has evolved from primarily a decentralized operation to its current centralized operation, where policy direction is maintained at the Assistant Inspector General level and implementation of these policies are carried out by operational headquarters divisions and regional offices. This alignment, a copy of which is included in my statement, provides a clear division of authority and responsibility, promotes cooperative audit and investigative reviews, and permits a flow of communication throughout the organization.

To keep pace with management priorities and improve operations, we have implemented a number of organizational and personnel changes since 1981. From an organizational viewpoint, the most significant changes have been to increase the number of regional offices from four to eight; collocate auditors and investigators; change the focus of the headquarters audit and investigative offices from primarily staff responsibilities to operational audit and investigative responsibilities; and establish an enhanced ADP division to provide ADP audit service, technical ADP support, and to develop advanced methods for using ADP in our audit and investigative work. At the same time, we concentrated on substantially upgrading the qualifications of the professional audit and investigative staff. In 1981, the Office of Inspector General staff consisted largely of personnel with VA program or general investigative experience. In 1987, through constant selective recruiting and both on-the-job and formal training, the staff now consists of professional auditors, analysts, and criminal investigators capable of fully implementing their responsibilities under the Inspector General Act of 1978.

We are currently authorized a staffing level of 381 and our requested funding authority for FY 1988 is $20.4 million. Our centralized administrative alignment permits us to maximize the number of personnel assigned to operational audit, investigative, and related activities. Accordingly, 345 of the authorized 381 level are assigned to operational types of positions, with the remaining 36 positions assigned to normal headquarters support positions.

OPERATIONS OF THE VA OFFICE OF INSPECTOR GENERAL

Audit--The Assistant Inspector General for Auditing is responsible for planning and conducting audits of VA programs and operations. Audit coverage is directed towards identifying opportunities for improved economy and efficiency in operations and better internal controls to help assure the integrity of VA programs and operations. Also, audit coverage is afforded to those areas in which the Congress, VA management, or OMB has expressed an interest, and other areas mandated for audit by law, regulation, or policy. Audit coverage of VA programs and activities is accomplished through a series of cyclic audits, and through a coordinated series of VA-wide audits of major programs. Cyclical audits concentrate on the effectiveness of internal controls and economy and efficiency of operations and programs at a particular site, whereas VA-wide audits assess the effectiveness of actions taken to implement programs throughout the Agency's medical and benefit systems.

Investigations--The Assistant Inspector General for Investigations is responsible for the investigation of fraudulent or serious administrative irregularities arising in VA's programs and operations. Criminal matters investigated are referred to the

Department of Justice for prosecution and, if necessary, subsequently referred to the agency for appropriate administrative action. Investigative operations are based on referrals (reactive investigations) of suspected wrongdoing to the Office of Inspector General, and independent probes (proactive investigations) of areas vulnerable to fraud.

Other Activities--The Assistant Inspector General for Policy, Planning and Resources is responsible for a host of operational and support activities for the Office of Inspector General. Operational activities include conducting oversight and other reviews of the VA Medical Inspector's Office, review and investigation of VA hotline complaints, monitoring the external pre- and post-award contract and grant audit program, and operation of the agency's personnel and information security office. Staff responsibilities of this office relate to such issues as planning, policy development, legislative review, freedom of information act releases, GAO liaison, and resource management functions.

ACCOMPLISHMENTS OF THE VA OFFICE OF INSPECTOR GENERAL

During the 6-year period FY 1981-1986, the Office of Inspector General issued 2,212 audit reports and opened 5,975 investigative cases. During this period, we reported, in accordance with the criteria established by the President's Council on Integrity and Efficiency, about $3.4 billion in potential monetary benefits. About $3 billion was classified as potential cost efficiencies (i.e. cost avoidances or better use of existing funds) and $400 million

was classified as potential cost recoveries (i.e., both actual dollar recoveries and commitments to seek recoveries). Also, the investigative work during this same period resulted in 1,809 prosecutive and administrative actions. In addition, much of our work was geared toward tightening internal controls and strengthening program integrity in which the results are not quantifiable in dollar terms.

The ultimate measurement of the effectiveness of our work is the action taken by management in response to our reports. The Office of Inspector General reports can serve as a catalyst for change, but program implementation and change must be carried out by Agency management. To help assure that action is taken, the Office of Inspector General follows up on each of its cyclical audits, during the next cyclical audit at that facility, and performs followup audits of program areas where significant reports have been issued. Also, we have been fortunate to have the full support of top Agency management for the results of our work.

Another yardstick used to measure the success of an Office of Inspector General program is a comparison with our peers in the Inspector General community. In the President's Council on Integrity and Efficiency Summary Reports for Fiscal Years 1985 and 1986, the VA Office of Inspector General ranked in the top group of the 17 Inspector General organizations in each of the three most meaningful performance categories-- potential cost efficiencies, potential cost recoveries and prosecutions.

Some brief highlights of the scope of VA operations and programs and the broad coverage afforded these operations and programs by my office are as follows:

For the Department of Veterans Benefits (DVB) where the annual operating budget is over $15 billion, and benefits are provided through a network of 58 regional offices and two insurance centers, the OIG reviews of operations and programs include:

(1) Cyclical audits every 3 years of each regional office to review the internal controls and efficiency of operations at these offices, (approximately 20 audits of this type are conducted each year),

(2) Departmentwide audits of major DVB programs to review the effectiveness of program implementation actions, (approximately 10 audits of this type are conducted each year), and

(3) Investigations geared primarily to the identification of fraud in benefit programs.

Examples of major areas of emphasis within DVB where significant audit and investigative work has been accomplished over the past 6 years are:

Loan Guaranty. Areas either audited or investigated included foreclosure procedures, underwriting, appraisals, loan applications, loan funding fees, property management, and mobile home sales.

Compensation and Pension Benefits. Ten state wage matches have been conducted to identify benefit overpayments and to investigate any fraud related to these overpayments.

Other Benefit Program Areas. Other DVB areas such as unemployability payments, aid and attendance benefits, education benefits, beneficiary debt waivers, payments to divorced or widowed veterans, and payments to incarcerated veterans have also been reviewed.

To provide medical care, the Department of Medicine and Surgery (DM&S) has an annual operating budget of about $9 billion and maintains 172 hospitals, 228 outpatient clinics, 16 domicilaries and 117 nursing home care units. The OIG reviews of DM&S operations include:

(1) Cyclical audits every 3 years of VA medical facilities to review the internal controls and efficiency of operations at these facilities, (approximately 60 audits of this type are conducted each year),

(2) Departmentwide audits of major DM&S programs to review the effectiveness of program implementation actions, (approximately 10 audits of this type are conducted each year), and

(3) Investigations in DM&S have centered on the identification of fraud in medical and related programs.

Examples of major areas of emphasis within DM&S where significant audit and investigative work has been accomplished over the past 6 years are :

Patient Placement. In this area, we have reviewed nursing home care, inpatient and outpatient psychiatry service, intermediate care, domiciliary care, and discharge planning.

Outpatient Eligibility. Areas reviewed were entitlement to care, fee basis care and verification of CHAMPVA payments.

Quality Assurance. Areas reviewed included physician licensure, nurse licensure, malpractice claims, patient outcome analyses, x-ray procedures, and procurement of drugs.

Medical Resources. Areas reviewed were contract rates for nursing homes, staffing the rehabilitation medicine program, medical care cost recovery, home oxygen program, and rehabilitation engineering center programs.

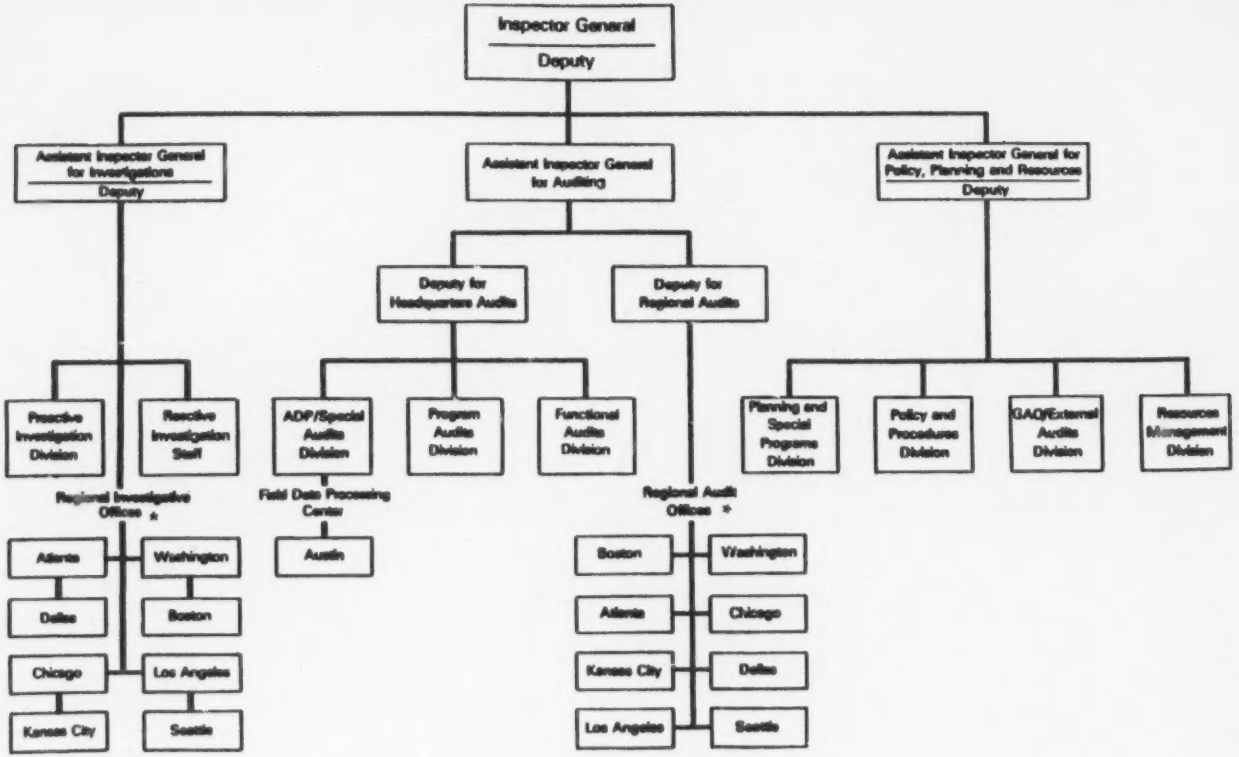
To provide burial services, the Department of Memorial Affairs (DMA), with an annual operating budget of about $48 million operates 109 cemeteries and 32 other miscellaneous sites. Because of the relatively small size of the DMA program, audit and investigative coverage has been limited. The emphasis to date has been placed primarily on employee integrity issues which has resulted in a number of administrative or judicial actions taken against DMA employees.

The VA's construction program, which is the second largest in the Federal government, with an annual budget of about $400 million also receives considerable coverage from the Office of Inspector General. During the period FY 1981-1986, our audit approach during each applicable medical center cyclic audit was to concentrate on the need for proposed construction projects in light of current and projected workloads. In FY 1987, our focus in the construction area began to shift from one of requirements justification to overall management of the construction contract administration process.

This emphasis on the contract administration process is expected to provide the bases for systemic recommendations to provide long-term improvements.

In summary, during my 6 years as VA Inspector General, it has been my policy to work together with Agency management to further our mutual goal of providing top quality care and service to all eligible veterans and beneficiaries. We fully expect that our program of independent audits and investigations will continue to assist the Agency in meeting their commitments to our Nations veterans.

Mr. Chairman, this concludes my testimony. My colleagues and I would be pleased to respond to any questions you may have.



* suboffices
Houston
New York
Philadelphia
St. Petersburg
San Francisco

* suboffices
Albany
Philadelphia

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

OVERSIGHT OF THE VA OFFICE OF INSPECTOR GENERAL

WASHINGTON, D. C. OCTOBER 8, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for affording the Veterans of Foreign Wars of the United States this opportunity to comment on the performance and operation of the Veterans Administration Office of Inspector General (VAOIG). The VFW wishes to commend the Chairman and the members of the Subcommittee for holding this hearing so that this mechanism for preventing fraud and abuse within the VA may be improved. The VA Office of Inspector General operates independently in conducting audits and investigations of the Veterans Administration's programs and operations. This office's main responsibility is recommending policies for the purpose of promoting efficient and effective operations while preventing fraud, waste and abuse within the Veterans Administration. Finally, the VAOIG is tasked with ensuring that the Administrator and the Congress are kept fully apprised of any problems or deficiencies which may exist within the VA along with recommending the necessity of corrective action.

In the VA Inspector General's semiannual report of October 1, 1986 through March 31, 1987, it is stated that the VAOIG has carried out a series of coordinated audits and investigations designed to identify opportunities to enhance the effectiveness, efficiency and integrity of Veterans Administration programs and operations. The report goes on to state that potential recoveries and efficiencies for the 116 audit reports and the 516 investigations totaled $304,000,000. This figure is comprised of $88,000,000 in potential recoveries for VA management to pursue in collections and the remainder may be achieved, according to the report, by implementing various recommendations resulting in the more efficient use of $216,000,000.

For its part, the Veterans of Foreign Wars strongly supports actions which will enable the Veterans Administration to more efficiently and effectively utilize its resources. We well appreciate that in this time of fiscal restraint and ever-increasing budgetary pressure that the only way the VA will be able to properly carry out its mission of serving this nation's veterans is through a scrupulous effort to operate as efficiently as possible. And, it is precisely in this area that the VA Office of Inspector General has important contributions to make.

On the other hand, it is also our concern that an exaggerated emphasis on cost avoidance and operational efficiency will result in diminishing the care and compassion provided veterans by the VA and will transform the status of veterans' entitlements and programs to that of mere ciphers in the accountant's ledger. The debt of honor this nation owes our veterans cannot be reckoned in dollars and cents alone, nor should it be repaid within the strict parameters of monies recovered and efficiencies achieved.

One particular area of VFW concern pertains to outpatient eligibility. The Inspector General's semiannual report states that eight medical center audits disclosed that improved controls should be implemented to ensure outpatient care is only provided to eligible veterans. It is indicated that at three medical centers, care was given to veterans not entitled to the level of care provided and that at five centers, fee basis medical care was provided to veterans who were not eligible. Although the VFW can appreciate the VAOIG's interest in saving money by enforcing the rules, we most certainly do not want to see veterans denied available care simply because they technically do not fully meet the eligibility requirements. To our way of thinking, if the care is available, veterans should be afforded treatment by the Veterans Administration. We believe that this compassionate provision of medical care does not truly tax the system. Furthermore, we would point out that the provision of outpatient care, along with helping a veteran

in need, usually saves the VA a considerable amount of money by avoiding the high cost of providing inpatient care. Thus, we take exception with the VAOIG's assertion that strictly limiting outpatient care will result in the more efficient use of $2.5 million. We believe that this sum and more, would be lost due to a consequent rise in the incidence of costly inpatient care and serious illness.

Another area of VFW concern is major construction projects. The VAOIG's report states that audits of four planned major construction projects resulted in recommendations for project cancellations and modifications that would reduce estimated construction cost by $101,000,000. It is stated that at one medical center work load projections were significantly overstated and did not justify the proposed clinic/bed addition project. At another medical center, the justification for a clinical addition privacy project included more beds than were needed, according to the VAOIG, it was not based on actual space deficiencies. A third medical center's plan to construct a new outpatient clinic had not considered use of existing space, had significantly overstated work load projects, and had not acknowledge eligibility criteria in projecting work load. Similarly, audits of minor construction projects at 20 medical facilities resulted in recommendations to cancel or reduce the scope of 81 minor construction and non-recurring maintenance projects. Although oversight of the VA's construction programs is an important element of the Inspector General's office, we do not wish to see OIG zeal for cost effectiveness result in its overruling VA medical and construction experts with respect to the needs of the VA's physical plant. In other words, we strongly oppose any OIG second guessing of VA experts that would result in a reduced number of VA health care beds and other resources being available to this nation's veterans.

In a different area, the VFW can appreciate the OIG's efforts with its long term computer matching project to detect overpayments and instances of fraud in the VA's compensation and pensions programs. We question, however, whether it would not be more wise and compassionate to apply this state-of-the-art investigative engine to the large contractors and suppliers with which the VA does business, rather than to disabled and pennyless veterans and their widows and dependents. Even if the $20.5 million in overpayments reported by DVB regional staff is accurate, we sincerely doubt that the VA will even be able to recover a small percentage of this figure. In fact, we cannot help but wonder if enough will be recouped even to pay this high tech investigation.

Another area of VFW concern pertains to the Diagnostic Related Groups (DRG) funding methodology. The VFW fully recognizes that improved discharge planning is the key to a hospital director's success with DRG. We also recognize that the Inspector General would perceive a fast inpatient turn around as being a perfect opportunity to save money. We cannot emphasize strongly enough that the focus on discharge must never overshadow the importance of full and complete treatment. Similarily, it now appears that the medical consensus calls for returning as many psychiatic patients as possible to various levels of the community. We are adamant that pressure from the Inspector General or, for that matter, any other source to speed up this process of returning psychiatic patients into society not result in sacrificing the effectiveness of treatment for the sake of economy.

The foregoing concerns and observations notwithstanding, the VFW also places great value on the role OIG is playing in affording the greatest number of veterans the best possible health care through the effective and efficient utilization of resources. Its efforts in fighting fraud in the mobile home industry is a prime example of the kind of beneficial work the VAOIG can do on behalf of veterans. Its efforts to eliminate such nefarious practices as invoice packing and undervaluing bills of sales on repossessed VA guaranteed mobile homes is very important. Furthermore, the VAOIG's efforts to investigate jointly with the FBI fraudulent activities in the real estate and home loan industries is proving highly valuable.

The VFW also recognizes the contribution made by the VAOIG in area contract audits. These audits pertain to VA contracts and grants performed or administered by contractors or grantees. The Defense Contract Audit Agency (DCAA) conducts the majority of these audits at the request of VA program officials in the Office of Procurement and Supplies and the Office of Facilities. The Inspector General's semiannual report for October 1, 1986 through March 31, 1987, indicates that audit reports contain a total audited costs of $145.3 million. Resolved audit reports resulted in cost efficiency of $1.1 million and commited recoveries of $500,000. OIG is to be commended in this action not only for having recovered funds but also because such work serves to decrease fraudulent and inefficient practices in the future.

Mr. Chairman, this concludes my statement, thank you on behalf of the membership of the Veterans of Foreign Wars for having invited our participation at today's hearing. I would be happy to respond to any questions you may have.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

October 7, 1987

Honorable Lane Evans, Chairman
Subcommittee on Oversight & Investigations
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

We request that the enclosed letter from Bob Lyngh, Director of our National Veterans Affairs & Rehabilitation Commission, be included in the permanent record of your Subcommittee's October 8 hearing regarding activities of the VA Inspector General.

Mr. Lyngh's letter is being submitted in lieu of formal testimony at that hearing. We appreciate your compliance with this request.

Sincerely,

E. Philip Riggin, Director
National Legislative Commission

The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

October 6, 1987

Honorable Lane Evans
Chairman
Subcommittee on Oversight and
Investigations
House Committee on Veterans Affairs
335 Cannon House Office Bldg.
Washington, DC 20515

Dear Mr. Chairman:

The American Legion appreciates the opportunity to submit to the Subcommittee its views on the operations of the Office of Inspector General of the Veterans Administration.

The Inspector General of the Veterans Administration at this time is Mr. Frank Sato. The American Legion has good relations with Mr. Sato. Our perception is that he is a conscientious and effective officer who fulfills his duties in a creditable manner and displays dedication to his office, the agency and the Government. When there are matters we wish to discuss, Mr. Sato is available; and he generally accepts invitations to speak to policy-making committees of The American Legion, to present and discuss the work of his office. This availability is very important in that it provides useful information to our organization and its members, and also allows for dialogue that tends to avoid or minimize misunderstandings about the work and the responsibilities of the office of Inspector General. We are sure it helps the Inspector General and his staff to carry on their work effectively and makes their presence at VA installations more acceptable by the VA's constituency - the nation's veterans.

The American Legion is well aware that presently all of the departments and agencies of the Executive Branch of the Federal Government are required by law to have an Inspector General. We understand the responsibility of these Federal officers is to minimize and as much as possible eliminate or avoid fraud, waste and abuse in the operations of the Executive Branch. As citizens and tax payers, members of The American Legion have to consider

this to be necessary work in the vast undertakings of the Federal Government. It is our wish and hope, as it is that of the Members of Congress that the Inspectors General will be diligent in their work and successful in meeting their goals. All activities that reduce fraud, waste and abuse and insure cost-effective expenditure of tax dollars in these days of Big Government, are commendable, necessary and essential to the functioning of the Government.

As to whether the office of the IG is adequately staffed to accomplish its mission, and whether the assigned staff is capable, is not for The American Legion to say. It has been the consistent policy of this organization not to become involved in VA staff operations. In our view it is up to Congress, the agency and the Office of the President to determine the level of needed staff and to select persons who meet the requirements of their job descriptions. We view our role as that of the consumers' representative, and mainly direct our efforts to help see to it that veterans and their dependents receive benefits to which they are entitled and for which they apply, on a timely basis. That is the thrust of most of the statements The American Legion submits to the Committees of Congress that have oversight responsibility for the VA.

We do receive copies of the semi-annual reports of the IG. Our review indicates to us that the IG has at all times numerous audits underway. We note also the report of savings effected, recoveries made and instances of fraud, waste and abuse identified and corrected. With all of this we are in agreement.

This leaves only one important area of concern we would like to bring to the attention of the Subcommittee in its oversight review of the work of the IG and his staff.

Our concern is that there have been instances where it has appeared to us that the IG's auditors have moved from the auditing of various aspects of VA operations, to superimposing their judgment on actions and decisions that in our view are the prerogative and the responsibility of program and administrative officers of the agency. We will herein discuss two of the areas that have drawn our attention. We should stipulate in doing so that we have in fact discussed these areas with the IG, and that officer is aware of our concern.

The first area is that in which IG auditors will review plans and operations at a VA facility, for example a Medical Center, and the auditors will move from evaluating the quality of work performed and cost-effectiveness, to an attempt to superimpose their judgment on that of the responsible officers as to the value of a given project.

Let us give you a current example of what we mean. In June, 1987, an American Legion Field Representative completed a routine survey at VAMC Fort Harrison, Montana. Here are two excerpts from Field Service Report No. 7-025, copy of which will be made available to the Subcommittee on request: 1) p.2 of the Report: The need for a Nursing Home Care Unit (NHCU) has been an assessed requirement for many years and would add another treatment dimension to this VAMC. Although a NHCU proposal had been previously approved as a MEDIPP initiative, the Inspector General's office claimed that its establishment was too expensive and that the outplacement of veterans to community nursing homes would be more cost-effective. The Inspector General's office proposed that the medical center, instead, convert 30 hospital beds to NHCU beds. Management maintains it is unable to do this as the existing hospital would be reduced to 136 beds after currently approved patient privacy remodeling projects are completed. An area is available for renovation into a nursing home facility in existing space on the first floor of the hospital. This area would need a small addition to meet nursing home care space criteria. The project, entitled "Renovation to Establish a 30-bed Nursing Home Care Unit" (FY 1990) is supported by past and current MEDIPP plans and is consistent with station and district goals of a 30-40-30 ratio of VA to Community and State Nursing Home care beds. Management emphasized that there were limited long-term care facilities in the State for patients with such debilitating diseases as Alzheimer's, Parkinson's and MS Diseases.
2) p.3 of the Report: ..... The Dietetic Service requires complete remodeling. The kitchen is not workflow efficient; asbestos requires removal; the ceilings on freezers are rotting through, in fact on one occasion, raw sewage broke through and completely flooded a freezer; and there is no separation between food preparation and dishwashing areas. Again, the Inspector General reduced renovation estimates and proposed piecemeal rather than complete remodeling. Other projects include air conditioning for Wards 3 and 4, air conditioning for the Outpatient Clinic, the renovation of Ward 3 South, and the Rehabilitation Medicine addition. The funding and completion of these projects are deemed indispensable to the delivery of quality health care.

We suggest to the Subcommittee that the District Planning Committee and the facility officers are the best judges of what are the most effective solutions to the problems discussed in this Field Service Report. It appears to us that what the IG is doing here is superimposing the opinions of auditors who are not trained in health care delivery on the judgment of the Department of Medicine and Surgery. We suggest the Subcommittee should talk to the IG about this and similar matters.

Which brings us to our other area of concern. We note that in addition to all the other audits being completed by the office

of the IG, that office has undertaken to review certain categories of compensation and pension awards, and to use their findings in these reviews to advise adjudicative officers in the Department of Veterans Benefits how cases should be rated. In fairness we must say the IG denies his auditors are doing their reviews in this way, but that is the way it looks to us.

The IG, for example, will send his auditors into a Regional Office and review all the psychiatric ratings made by the Rating Boards over a given period of time. If the curve of allowances is higher than the system-wide norm, then the auditors will start pulling cases, and checking the Rating Board actions. If the auditors decide the Boards are granting too many 100% ratings for a given diagnosis, they will recommend that all such cases by a certain Board should be reviewed and possibly re-rated - with or without another physical examination of the veteran. We use this description of our perception of IG activities as an example, but the actual work of the auditors can cover the entire spectrum of physical disabilities for which the VA pays compensation to service disabled veterans.

In the first place, we object to IG auditors superimposing their judgment on that of three member Rating Boards who have the expertise and the experience required to assign ratings from the Rating Schedule. These auditors have no training in the rating of cases. And, however much they may have read the Program Guides, the Rating Schedule and the Physicians' Guide, they are not qualified to use their personal judgment to ask a Rating Board to re-rate cases that have been subjected to the review and rating process established for that purpose by DVB.

We would be inclined to agree that if a review by IG auditors indicated that a specific Regional Office or Rating Board was deviating from the system-wide norm in rating a certain category of case, this could be brought to the attention of the Chief Benefits Director, which would result in the Director ordering a review to be accomplished by the Compensation and Pension Service. That, in our opinion, is the way the system should work. But we must tell the Subcommittee that we take vigorous exception to any effort by the IG to tell the DVB that it is rating cases improperly.

Another aspect of this particular activity would be the reverse procedure. While we have been made aware of reviews completed by the office of the IG, concerning the rating of categories of cases too high in comparison to the system-wide norm, we have not been told of any similar reviews on which the IG has acted, where a Rating Board was found to have rated cases too low in comparison with the norm. We understand the IG has the responsibility to protect the interests of the Government in the administration of veterans benefits. We wonder, does that officer have any responsibility to do anything at all to protect the interests of those veterans who are required as a result of disabilities incurred in service, to seek assistance from the Government they served? If not, may we then ask - who does?

The conclusion of our observations is that The American Legion understands and supports the role of the Inspector General in the administration of veterans benefit programs. We believe at the same time there is a need for Congressional oversight to assure the IG understands not only the dimensions of, but also the limitations to the responsibilities of the office. The American Legion wants the interests of the Government protected. And we have an equal desire to see that the needs and the interests of veterans and their families are protected. We commend the Subcommittee for providing oversight of the VA in this important area.

Sincerely,

R. E. Lyngh

R. E. LYNGH, Director
National Veterans Affairs and
Rehabilitation Commission

DISABLED AMERICAN VETERANS
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October 28, 1987

Honorable Lane Evans, Chairman
Subcommittee on Oversight and
Investigations
House of Representatives
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Evans:

Thank you for your letter inviting the DAV to testify at the October 8, 1987 hearing conducted by the Subcommittee on Oversight and Investigations on the Veterans Administration's Office of Inspector General.

The DAV very much appreciates your invitation to testify, however, as we informed your staff prior to the hearing, we request this letter be included in the Subcommittee's hearing record.

As you know, Mr. Chairman, the objectives of the VA's Office of Inspector General are to prevent and detect fraud, waste and abuse in the expenditure of VA funds and to promote efficiency, economy and effectiveness of VA programs and operations.

In the furtherance of these objectives, the VA's Office of Inspector General has conducted thousands of audits and investigations of various programs and operations. As a result, the Inspector General has issued a variety of recommendations and opinions to VA management effecting these programs.

Mr. Chairman, the Disabled American Veterans acknowledges the importance of the activities of the Inspector General that have ferreted out schemes that were defrauding veterans and/or the government. The IG's prerogative to audit and/or investigate any of the various VA programs and operations is, in our view, fully within the purview of their legal mandate, so long as such audit/investigation does not undermine the legal/regulatory basis upon which the program or operation was created.

In this regard, the DAV believes the VA's Office of Inspector General has, with respect to at least one audit, exceeded their legal authority. Specifically, in 1985 the IG conducted an audit that matched the federal employment records of disabled veterans who were federal employees and, who were compensably disabled for service-connected mental disorders.

As a result of this audit, the IG identified 2,568 veterans. Of those, they found that 2,044 were full time federal employees who earned from $10,000 to $63,800 a year. The IG recommended to the Chief Benefits Director that a priority review of all unprotected compensable mental disorder cases with verified annual salaries of $25,000 a year or more be completed. This review was to evaluate the current degree of disability and implement annual employment reporting controls.

At that time, Mr. Chairman, the DAV seriously questioned both the conclusions of the audit and the method by which it was conducted. It was obvious that this audit of service-connected disabled veterans rated from 10% to 70% for mental disorders reflected blatant disregard for both individual rights to privacy and the intent of the law granting service-connected disability compensation benefits.

Clearly, the audit demonstrated the federal government's ability to violate the individual rights of government employees and completely ignored the law governing the primary basis of disability ratings -- one that awards compensation on the basis of the mental disability's impairment of earning capacity and social adjustment.

Following the completion of this audit, the IG proposed to expand this program of computer matches between VA compensation records (of those veterans with service-connected compensable mental disorders) and state and local wage, tax and employment security records.

As a result of the objections raised by the DAV and some members of Congress, the IG did not proceed with their proposed expanded computer matching program.

However, as we understand, the responsibility for such an audit has been delegated to the Chief Benefits Director who has proceeded with the matching program of state and local wage, tax and employment security records.

Quite frankly, Mr. Chairman, this type of audit, initiated by the IG and now continued by the Chief Benefits Director, smacks of a "back door" means test on service-connected disability compensation benefits. As you know, VA regulations make clear that the mere fact of employment does not, in and of itself, suggest ineligibility to a compensable evaluation for a service-connected mental disability.

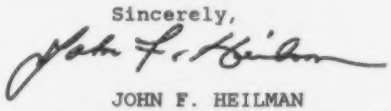
In addition, a veteran's level of earnings at any given time is insufficient proof of an improvement in the severity of the veteran's disability to warrant a rating review. Obviously, this approach reflects a prejudicial attitude towards veterans with mental disorders.

The DAV firmly believes that any action or plan devised by the IG or the VA to apply a means test to disabled veterans who have made a success of their lives in spite of their service-connected disabilities is totally inconsistent with existing law and regulations.

Therefore, Mr. Chairman, the DAV encourages you and the members of the Subcommittee to continue to closely monitor the activities of the VA's Office of Inspector General to ensure that future activities do not infringe upon the legal basis upon which VA programs and benefits were created and upon the individual rights of privacy of our nation's veterans.

Again, Mr. Chairman, the DAV appreciates this opportunity to comment on this most important matter.

Sincerely,



JOHN F. HEILMAN
National Legislative Director

JFH:lrd

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October 21, 1987

Mr. Frank S. Sato (50)
Inspector General
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Mr. Sato:

In conjunction with the Oversight and Investigations Subcommittee hearing of October 8, 1987, enclosed are a number of additional questions for your response. These questions and the answers which you provide to them will be made a part of the official record of the hearing. Receipt of your responses to these questions by November 20, 1987, would be appreciated.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers on legal size paper, single spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

LANE EVANS
Chairman
Subcommittee on Oversight
and Investigations

LE/pgp
Enclosures

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. LANE EVANS TO VETERANS' ADMINISTRATION

QUESTION 1 : The VA Annual Report for 1985 stated that IG investigations and audits highlighted the need for improvements in medical care quality assurance. In 1986, the VA Annual Report stated more audit and investigative coverage was given to medical care quality assurance by the OIG and significant results were achieved. Please describe both the needed improvements and significant results in medical care quality assurance referred to in these two VA Annual Reports.

ANSWER: Our primary coverage of the VA's quality assurance program is carried-out through our regular schedule of cyclical and program audits. In the past 2 years, we have completed major audits in such quality assurance (QA) areas as physician licensure, nurse licensure, ineffective drugs, unneeded x-rays, medical risk management, quality standards for professional programs, incident reporting, etc. Each of these audits dealt with important QA issues and, in my opinion, have led to further improvements in these programs.

Another part of our QA coverage is accomplished through our oversight of Medical Inspector (MI) cases and station incident investigations. We review each MI case and a sample of the station investigations. When we have questions about the case, we refer them back to the MI for further review. We also trend all incident reports, which gives us a lead on possible repeat offenders, medical centers not reporting properly, medical centers with unusually high rates of certain types of incidents, etc.

In Fiscal Years 1985 and 1986, a series of audits was conducted addressing the medical quality assurance program. As a result of our findings, significant improvements have been initiated. Examples include the following:

Audit of Quality Standards for Professional Programs (5AB-A01-12)

A 1985 review of accumulated data on mortality rates for surgical procedures associated with 52 Diagnostic Related Groupings determined that mortality rate analysis could enhance the quality assurance program. As a result, new legislation requires the VA to collect data on mortality and morbidity rates for each surgical procedure for use in comparison with national rates.

Audit of Licensure Status of VA Physicians and Nurses (6AB-A99-147; 6AB-A99-149)

Two 1986 reviews of VA physician and nurse licensure status determined that credentialing procedures needed to be strengthened and that VA needed to enter into an exchange of information with state and national credentialing agencies. Legislation now charges the VA with establishing "credentialing information exchanges" with state medical licensing entities, the Federation of State Medical Boards, and the American Medical Association as means to improve physician and nurse credentialing procedures. VA has developed a new application form which requires full disclosure of all licenses

previously held by physicians and nurses and has made arrangements to verify licensure status with the Federation of State Medical Boards and the National Council of State Boards of Nursing.

Audit of Medical Malpractice Claims (5AB-A17-119)

A 1985 review of medical malpractice resulted in the development of a profile of VA's malpractice experience and demonstrated the need for enhancing the quality assurance program to identify the causes of medical misadventures. Computer equipment has been acquired to analyze malpractice claims and patient incident reports to upgrade the risk management.

Review of Drugs Rated Ineffective by the FDA in DM&S Medical Centers (6AB-A99-101)

A 1986 review of drug usage at VA medical centers found FDA rated ineffective drugs being prescribed to VA patients. A major VA policy revision has been made to preclude the use of any drugs which have been classified as ineffective by the Food and Drug Administration.

QUESTION 2: How many medical professionals are currently on the IG's staff?

ANSWER: The IG does not have any medical professionals directly assigned to its staff. We do have the authority to hire such specialists in the medical field, if necessary. However, in lieu of hiring, we have obtained the services of medical personnel, as the need arises, from within the VA or from other government agencies. For example, we have been assisted by medical personnel from DoD, GAO, and HHS. Further, we have employed the services of the VA's Medical Inspector on numerous occasions and are often assisted by VA physicians at the sites we audit. We have been very successful in obtaining the necessary medical expertise by following our current procedure. However, we would not be hesitant in soliciting medical personnel for permanent positions in the OIG if a continuing, full-time requirement arose that warranted such hiring.

QUESTION 3 : Does the Office of Inspector General have a written annual work plan? Does it contain and explicitly state OIG priorities, goals and objectives? How is it developed and how is it used?

ANSWER: The Office of Inspector General has a written operations plan. Input to the plan is requested from Agency managers. The plan is updated and published semiannually. It is used to communicate the current Office of Inspector General audit and investigative efforts and to provide a basis for monitoring performance. The plan is based on the OIG strategic planning issues which identify the audit and investigative priority areas. The issues are developed through consultation with Agency program managers, results of our prior years work and our analyses of current topical areas.

The Office of Inspector General's first priority is the accomplishment of audits required by the cyclic audit program for VA field stations, followed by support for audits and investigations that became necessary due to special circumstances or requests.

Beyond these basic objectives, we have developed a set of strategic planning issues that are intended to provide broad policy and program direction in formulating plans for audits and proactive investigations. For example, in Fiscal Year 1988, we are focusing on five key program areas.

- o Patient care: concentrating on quality assurance and patient management
- o Support functions: such as procurement and automated data processing (ADP)
- o Financial management, debt collection, financial reporting
- o Construction contract administration
- o Benefit programs: especially loan guaranty and compensation and pension authorizations

These planning issues reflect our desire to be supportive of the overall goals and objectives of the Agency as well as key initiatives in the Presidential report, "Management of the United States Government." We are also coordinating our efforts with major initiatives of the President's Council on Integrity and Efficiency (PCIE), notably in the areas of ADP systems, financial management, and guaranteed loans. Our increased emphasis on controls over quality of patient care reflects our desire that our efforts go beyond ensuring that VA funds are used as efficiently as possible to ensuring that they are used to provide the greatest possible benefit to our veterans.

To accomplish its mission, the OIG plans its workload activities carefully. The planning process requires the evaluation of the VA environment, the establishment of long-range objectives and short-term goals, and the identification of alternative ways to achieve these goals and objectives. The environment includes the inherent risks, political factors and operational constraints in VA programs. The planning process facilitates developing a semi-annual schedule for audits and investigations responsive to mission accomplishment.

The major OIG reviews are:

(1) Facility Audits. Timely, comprehensive evaluations of the efficiency and effectiveness of VA operations and internal controls. All VA facilities are on a 3-year cycle.

(2) Program and Functional Audits. Comprehensive evaluations to identify policy and procedural improvements and recommend actions to optimize service delivery on a cost effective basis.

(3) Investigations. Timely reactive investigations of individual cases with high probability of criminal prosecution or significant administrative action and proactive investigations to uncover, identify, and prevent fraud and abuse.

The workload is assessed on a continual basis by reviewing the VA universe, e.g., the organizations, programs, activities, and functions subject to audit and proactive investigations. The objective is to identify significant universe activities in priority

order to determine the type of OIG coverage to be performed and the level of coverage necessary. Objectively measurable factors are used to identify significance and to assign priorities. Areas to consider include:

(1) Statutory and regulatory requirements;

(2) Adequacy of internal control systems as indicated by vulnerability assessments and internal control reviews required by OMB Circular A-123, "Internal Control Systems;"

(3) Newness, changed conditions and sensitivity of the organization, program, activity, or function;

(4) Current and potential dollar magnitude; and

(5) Prior audit and investigation experiences. This consideration has proved to be an extremely valuable source for identifying VA programs in need of audit because of the frequency of our cyclical audits and reactive investigations.

At least annually, a planning strategy is developed for the next Fiscal Year to focus OIG resources on issues with high potential for improving services to beneficiaries and their families and for reducing fraud, waste, abuse or mismanagement. Priorities for reactive investigations are revised as appropriate. Background information is developed and distributed on programs and operations and associated potential issues. Senior OIG management officials review the issues and associated background information to determine the coverage, frequency, and priority of each. Considered during the review are management needs to be met, including key management decision dates, as developed in consultation with the responsible program officials and senior management, and the availability of audit and investigations resources.

Next, at least twice a year, key staff members for headquarters and the regions meet to develop strategies for the next 6 months. During the conferences, staff members evaluate audit and proactive investigations for subsequent translation into Operations Plans. Proposals under consideration are supported by briefing papers.

Then the OIG finalizes the specifics of its operating plan on a semiannual basis. Using that as the basis, the OIG audit plan calls for about 40,000 staff days of audit effort annually. This year's plan spread the estimated staff days among different categories of audit as follows:

Category of Audit	Staff Day Percentage
Field Facility	60%
Program/Functional	35%
Hotline/Complaints/Fraud Prevention	5%

The investigation plan estimates about 11,000 annual staff days. These are distributed among the four fraud priorities as follows:

Fraud Priority		Staff Day Percentage
I	Above $25,000	65%
II	$10,000 - $25,00	25%
III	$1,000 - $10,000	7%
IV	$1,000 or below	3%

In summary, the Plan ensures that (1) the operations of approximately one-third of the over 230 VA facilities are comprehensively audited each year, (2) upwards of 20 of the major VA-wide programs or functions are audited annually, and (3) the most significant and sensitive fraudulent or criminal acts are investigated.

QUESTION 4 : Is the effectiveness of the OIG annual work plan evaluated? What was the result of the most recent evaluation and when was it conducted?

ANSWER: The effectiveness of the OIG work plan is continually assessed by OIG management through the results of our audit and investigative work. The results have been considered successful. In addition, as part of the development of planning for each following period, the current plan is reviewed by the planning group for topical currency and updated as needed.

A formal evaluation of the planning function by an external group is scheduled during the planned review of VA OIG operations by the GAO in FY 1988. This review is part of a series of reviews of government OIGs by the GAO and will include analysis of the work plan. The results of the GAO review will be used by OIG officials in their management of the planning function.

QUESTION 5: Both on-the-job and formal training for IG staff were mentioned in your prepared statement. Is there a written training plan for the OIG staff? Is any training required to be taken? How many staff have received some required training? How many staff have received all required training? Is optional training available? Is the training provided relevant to professional activities?

ANSWER: The staff training plan consists of a combination of formal training and on-the-job training. The program is designed to enhance the employee's audit or investigative skills and provide a thorough understanding of the mission of the VA and its programs.

The preparation of an OIG staff for the task of reviewing the complexities presented in the VA begins with recruitment. Applicants go through an intensive selection process that includes analysis by the interviewer or rater of the applicant's ability or knowledge of audit or investigative principles and practices, data gathering and analysis, and oral and written communications and reporting. This selection process lays the foundation for the OIG staff.

The auditors and investigators then are required to enter a formal training program, which provides on-the-job training via structured rotational assignments interspersed with periods of classroom training. For example, all newly hired auditors are entered into a 2-week basic training course, usually during their first 6 months of duty. During this past year, 47 auditors completed the course. The curriculum included technical audit areas such as workpaper preparation, interviewing techniques, report writing and advanced audit techniques such as *ADP microcomputer usage and statistical sampling.* The VA's mission, programs, and functions are used as the basis for the presentations by the instructors to aid the course participants in their familiarization process with the VA.

Likewise, newly hired investigators are sent to an 8-week criminal investigator basic training program conducted by the Federal Law Enforcement Training Center. The emphasis in this intensive course is to teach the proper application of investigative skills.

In summary, all audit and investigative staff have received the required basic training. After that, additional varied training is provided as discussed in the following paragraphs.

Formal classroom training continues periodically throughout the career of our auditors and investigators. Auditors have received formal training in areas such as advanced uses of microcomputers and associated software programs, internal control reviews, cost and price analyses, and refreshers in auditor skills. Investigators have completed formal courses in areas such as white collar crime, procurement, fraud, privacy act, and investigative refreshers.

The on-the-job training mode has proved to be a most successful means of providing training. Here we have senior auditors instructing junior auditors or senior investigators instructing junior investigators in live situations. Not only are the skills and abilities improved on the spot, but also the employee's knowledge of the VA is increased significantly. Through a series of our cyclical audits of VA facilities, the OIG employee becomes well versed in the programs and functions of the VA. By the time the OIG employee reaches the senior or management level, he or she is quite adept at auditing or investigating many of the VA functions or programs. This acquired knowledge can be passed to the junior or less-senior auditor.

In addition to the aforementioned training, we have been able to utilize quite extensively the services of VA personnel to provide detailed information and guidance on the operation of many VA programs. The VA personnel have been more than willing to provide this assistance to us. Examples include the Resources Allocation Methodology (RAM), contract administration, loan underwriting practices, and patient treatment file reviews.

In summary, through continuing training and a free access to VA information, our OIG staff has been made fully prepared to tackle the complexities of auditing or investigating the VA.

QUESTION 6: According to your submitted testimony, 345 staff of the authorized staff level of 381 have "operational types of positions". What is the meaning of "operational types of positions"?

ANSWER: The "operational types of positions" are professional auditors, analysts, and criminal investigators who establish policy and plan and perform audits, investigations, and related reviews of VA programs and operations. Included in these related operational activities are oversight reviews of the VA Medical Inspector's office, reviews and investigations of VA Hotline Complaints, monitoring of the external pre- and post-award contract and grant audit program, and operation of the security office.

QUESTION 7: How many audit staff and investigative staff have supervisory responsibilities? What is the ratio of audit and investigative staff to supervisory staff?

ANSWER: Of the audit staff, 45 have supervisory responsibilities. Of the investigative staff, 18 have supervisory responsibilities. The ratio of audit staff to supervisory staff is 6 to 1; the investigative staff to supervisory staff ratio is 4 to 1.

The audit staff ratio allows us to provide extensive staffing for indepth and broad audits of VA programs and activities. The lower investigative staff ratio is necessitated by the number of specific incidents that must be investigated on an individual basis.

QUESTION 8: Is the performance of OIG staff evaluated on a regular basis? Do professional standards for audit and investigative staff exist? Is compliance with professional standards considered in staff performance evaluation?

ANSWER: The performance of the OIG staff is evaluated on a regular basis. Separate, but similar systems are utilized to evaluate managerial personnel (GM-13 and above) and staff personnel (GS-12 and below). Established procedures require interim appraisals (e.g. at the end of each audit) and mandatory appraisals (mid-year and annually).

The appraisals are based upon individual sets of established professional standards for auditors and investigators. The standards normally are developed for each grade level and consist of several specific elements of performance. The employee's performance is measured against the specific standards by the appropriate supervisor. The evaluation is then communicated to the employee. This system ensures that both mangement and staff are continually appraised of their respective performance levels.

The foundation of the standards applied to our employees is based upon the published professional standards of the audit and investigative community. In the audit environment, our employees are required to closely adhere to the Standards for Audit of Governmental Organizations, Programs, Activities, and Functions by the Comptroller General of the United States (General Accounting Office). The investigators follow the Quality Standards for Office of Inspector General Investigation organizations issued by the President's Council on Integrity and Efficiency (PCIE).

QUESTION 9 : Does the OIG conduct an internal assessment of IG activities and accomplishments? Which activities of the OIG are subject to internal review or evaluation? What were the results of the most recent such review or evaluation?

ANSWER: The OIG conducts regular internal assessments of OIG audit and investigation activities and performs annual risk assessments to identify any internal control weaknesses.

Internal assessments include a peer review program that provides for independent evaluation of each headquarters and field audit and investigation operating unit approximately every 3 years. The results of these assessments, which are performed by

senior staff not assigned to or in charge of the applicable office, are summarized in internal reports to the IG. Recommendations for improvement and corrective action plans are included in these reports.

Also, an independent quality assurance review of audit reports issued is performed by the Policy and Procedures Division. This assessment, which is performed on a sample basis, is intended to assure that reporting is in accord with OIG directives and professional standards. Recommendations for improvement are directed to the applicable Assistant Inspector General. Furthermore, on a selective basis, audit workpapers supporting these reports are reviewed to assure that they are in accord with OIG policy and professional standards.

The results of the most recent peer reviews have emphasized improved supervision, documentation, planning, and staff retention activities--e.g., establishment of suboffices to reduce travel burden and staff losses.

In accordance with OMB Circular A-123, Internal Controls and the Federal Managers Financial Integrity Act, OIG annually evaluates various internal controls to identify any weaknesses. Such assessments include our Management Information System, budget activities, personnel administration, procurement, travel, and security activities.

QUESTION 10: There are two types of audits mentioned in the Semiannual Reports issued by the IG, external and internal audits. Please describe the purpose of each type of audit and any difference between them.

ANSWER: Internal Audits: These are management-type audits of VA programs and operations. The audit work is accomplished entirely by the staff of the Assistant Inspector General for Auditing. The audit reports contain recommendations for improving the programs and operations of the Agency. The audits account for about 50 percent of audit reports issued.

External Audits: These are audits of contractors who provide supplies and services to the VA and grantees who use VA funds. The pre- and post-(contract) award audit work is accomplished primarily by DCAA on a reimbursable basis.

Preaward audits assist contracting officers in conducting price negotiations primarily on price proposals. Post award audits are geared to discovery of defective pricing in fixed-price contracts and the allowability of costs incurred in cost-reimbursable contracts and grants.

OIG auditors conduct defective pricing reviews on a selected basis considering available audit resources and potential dollar recoveries.

QUESTION 11: When audits costs are compared to achieved efficiencies and recoveries, are external or internal audits more effective on a cost-benefit basis? What percent of the OIG audit budget is used to conduct internal audits, what percent is used to conduct external audits?

ANSWER: In Fiscal Year 1987, the OIG had an overall 60:1 benefit-to-cost ratio based on efficiencies and recoveries of approximately $1.2 billion compared to

total costs of $19.2 million. These benefits are attributed to the results of internal and external audits and investigations. Internal audits resulted in a 77:1 benefit-to-cost ratio; whereas, external audits yielded a 106:1 ratio. About 77 percent of the OIG budget is used to conduct internal audits, while about 3 percent of the budget is used for external audits.

QUESTION 12: Audits are referred to as "resolved" and "unresolved". What is the current definition of a "resolved" audit and an "unresolved" audit? Have these definitions changed over the years?

ANSWER: A "resolved" audit refers to a report on which either: (1) management has provided completed or planned actions to correct the cited conditions, and the actions are considered acceptable by the OIG; (2) management and the OIG reach an agreement on the actions to be taken; or (3) the Deputy Administrator of VA determines the actions to be taken. The latter case is applicable in those few instances when the OIG and the program directors cannot agree on audit resolution.

An "unresolved" audit is one on which management and the OIG have not reached an agreement on the actions to be taken, or the Deputy Administrator has not made a decision on the actions to be taken.

To our knowledge, OMB first defined "resolution" in Circular A-50, "Audit Followup," in September 1982; and this definition has not changed. Prior to that time, the VA had used the terms "completed" or "closed" to mean recommendations had been implemented and the OIG had tracked all recommendations until management had reported that actions had been completed. Based on OMB's definition of "resolution" and the guidance contained in Circular A-50, the VA revised its audit followup system to require OIG involvement only to the point of resolution, with management required to track recommendations until they had been implemented.

OIG places emphasis on testing the adequacy of corrective actions during subsequent audits in the subject area and/or at the VA facility.

QUESTION 13: When the statement "all issues in this report are considered to be resolved" is contained in an audit report, does this mean that agency management has agreed with the findings and implemented the recommendations contained in that report? If not, what does this statement mean?

ANSWER: The statement "all issues in this report are considered to be resolved" means that agency management has either agreed with the findings and has presented an implementation plan or has presented sufficient evidence to convince OIG that additional action is not necessary. In the latter case, there is usually high-level discussion and review of additional information prior to agreement that additional action is not necessary.

In most cases, management presents acceptable implementation plans that, if fully implemented, will correct the cited condition. Since the completion of all actions, e.g., new regulations,

could require significant time, we do not keep the report open. However, during our next audit, a priority review area is to assess the adequacy of implementation actions resulting from the prior audit.

QUESTION 14: Is the Veterans' Administration Office of Inspector General adequately and appropriately staffed?

ANSWER: Since FY 1983, the OIG authorized total staffing level ranged from a low of 345 in 1983 to a high of 385 in 1985. The current level of 381 will decrease to 377 in 1989. The vast majority (about 90 percent) consists of auditors, analysts, and investigators who are responsible for accomplishing the overall workload requirements of the OIG through various types of audits and investigations. For example, facility audits include comprehensive or selected reviews of VA field facilities on a 3-year cyclical basis. Program/functional audits enable the OIG to conduct system-wide audits of major VA programs and operations. Hotline reviews cover the specific issues brought forth by complaints of wrongdoing by employees, veterans, and the general public. External audits report on the reviews of VA contractors. Investigations cover either serious criminal and administrative irregularities (reactive investigations) or indications of criminal activity or abuses in selected program areas (proactive investigations).

We have recognized on several occasions that additional personnel would enhance our ability to provide increased and more indepth coverage of the VA. We noted that an increase in employment levels would enable the OIG to conduct more proactive investigations in major VA programs (e.g. fee basis, construction, procurement, supply, etc.); further assess and monitor the VA quality assurance program; perform more comprehensive audits of medical centers; regional offices, and major VA programs and functions; and stay current with the increasing investigation caseload. The OIG's most recent Five-Year Plan cited a need for 40 additional personnel to accommodate this workload. Therefore, in response to the first part of the question, an increase in staff in terms of overall numbers would allow us to cover in more depth the large programs of the VA.

In regard to the second part of the question, we believe the current mix of auditors, analysts, and investigators provides a very appropriate means to review the complex programs of the VA. Not only the depth, but also the breadth of their experience and knowledge has enabled our staff to effectively employ audit and investigative techniques to evaluate the broad issues covered by the VA. We, as well as other OIGs governmentwide, have found that persons with these skills can quickly comprehend most any program or function and successfully complete an evaluation of it. Through thorough research of the issue at hand and the use of their audit or investigative skills, the OIG employees invariably ask the right questions. OIG employees are taught to obtain extensive background information and criteria on the subject so that they have a basic understanding of the issue prior to initiating a review. Further, the employee's ability to be a "quick study" allows OIG management great flexibility; as priorities or interests shift

from program to program, these same auditors, analysts, and investigators can also quickly shift their approach or techniques to review those programs. Also, as their ability and knowledge broaden to incorporate several of these programs, they can more accurately judge the impact of one program on the entire VA system. On the other hand, specialists in one discipline as permanent staff may detract from our flexibility as priorities change and may not fully appreciate the impact of one program on the overall system. We have and will continue to obtain services, assistance, and information from specialists as needed. However, on an overall VA basis, the limited mix of disciplines we employ in the VA OIG has been and will continue to be appropriate to review the complex VA programs.

QUESTION 15: Is existing authority to deter and prevent waste, fraud, abuse and mismanagement adequate and sufficient?

ANSWER: The current authority accorded the Inspector General through legislation and through our organizational relationship with the Veterans Administration is for the most part adequate and sufficient to deter and prevent fraud, waste, abuse, and mismanagement. Our auditors and investigators generally have appropriate access to personnel, material, and records necessary to perform audits and investigations.

To further aid our efforts to collect evidence that is essential to our criminal investigative mission, we are seeking the authority for our special agents to request the issuance of search warrants. Our request for this very important authority is being coordinated with the Department of Justice.

We also have noted that two additional issues impact our authority. First, pending legislation to limit the use of computer matches would adversely affect our authority to accomplish our mission. Further, strict adherence to the requirements of the Paperwork Reduction Act either delays our ability or hampers our authority to perform our work.

QUESTION 16: Does the OIG conduct a cost-benefit analysis for each computer match? Have all computer matches been cost-effective?

ANSWER: Computer matching, the comparison of VA data bases with data bases of other agencies, has proven to be one of the most effective methods by which VA's monitoring responsibilities can be accomplished. To date we have expended approximately $1.4 million to identify approximately $40 million in overpayments and have achieved $3.3 million in repayments. The overall ratio for costs incurred to debts established is 1:28.6 and for repayments, the rate is 1:2.3.

Instead of conducting a cost benefit analysis for each computer match, we conduct a vulnerability or risk analysis to assure that each audit area selected for computer matching is an area that has a high probability for error, fraud, waste, or abuse. For instance, our audits in the controls over professional licensure of physicians and nurses would not have been possible without the use of computer matches. On a pure cost versus benefit basis the audit would not result in a dollar

quantifiable benefit. However, the conclusion was that the audit was beneficial. The audit resulted in a complete rewrite of the employment application to identify all disciplinary action, established a new control in the agency to require periodic matching with licensing agencies, and helped support legislation to require the agency to periodically check on health care licenses.

Our matches have been cost beneficial both in program impact and in cost avoidance or cost efficiencies. Our computer matching effort and the results of that effort have resulted in enhanced service to our veteran beneficiaries.

QUESTION 17: Does the OIG solicit or receive audit or investigation recommendations from veteran service organizations?

ANSWER: The Inspector General periodically meets with and addresses the officials and members of veteran service organizations during conferences, seminars, briefings, etc. held by the various organizations. Oftentimes during these meetings, the OIG's audit and investigative plan is discussed either specifically or in general terms. By doing so, the organizations are provided an opportunity to input suggestions for the OIG work plan. Most recently, the OIG responded to a request by a veteran service organization for a review of the Post-traumatic Stress Disorder (PTSD) program. In addition, audit teams often utilize published reports by veteran service organizations when developing plans for cyclical audits of specific facilities.

QUESTION 18: According to your prepared testimony, "The ultimate measurement of the effectiveness of our (OIG) work is the action taken by management in response to our reports." To make this measurement of the effectiveness of the work of the OIG, an assessment of the response of agency management to OIG reports is required.

Has the response of agency management to OIG reports been assessed? How was this assessment made, what information was utilized and what was the result? Based on the results of this assessment, how effective has the work of the OIG been?

Can this measurement of the effectiveness of the work of the OIG be made without an assessment of action taken by agency management in response to OIG reports? If yes, how?

ANSWER: The Office of Inspector General, in response to the support given by the Administrator and Agency top management, is committed to continually assessing the implementation and impact of our report recommendations. The assessment of the response of Agency management to our audit recommendations begins at the time that our audit report is issued and generally ends upon full implementation of the recommendation. During the initial briefing to management on our audit finding, we begin the process of assessment by seeking management's plans and timetable for the implementation of our recommendation. During the period from acceptance of the recommendation to full implementation, the status of implementation is tracked.

The audit recommendation and resulting management action are reviewed in two distinct ongoing processes. Significant recommendations made during cyclical audits of field facilities are followed up during the next regularly scheduled audit, generally 3 years later. If a recommendation has not been implemented, it is cited as a repeat finding and raised to the attention of the department or staff office head. This action, generally, is sufficient to assure full implementation. In the instance of program audits, we generally look for the implementation by assessing the impact during cyclical facility audits or by special followup audits. These processes are our normal followup procedures augmented with reviews of the Agency's followup procedures once every 2 years.

OMB Circular A-50 requires the OIGs to conduct an audit of the Agency's followup system. Our last followup audit was completed on March 31, 1986. This report confirmed that the VA's audit followup system was generally functioning effectively. We found no significant problems with audit followup and implementation activities for a sample of 10 external and 4 GAO audit reports reviewed. However, we did find that improvements were needed in the followup process for OIG internal reports.

Our review found that 4 of the 21 OIG internal audit reports reviewed experienced a breakdown in the audit followup process. This occurred because auditees prematurely terminated audit followup activity or decided not to implement the recommendations according to originally negotiated agreements. We made recommendations to the Deputy Administrator to (1) assure followup activity is continued until implementation of recommendations is actually accomplished and (2) require departments and staff offices to notify the Deputy Administrator and Inspector General if audit recommendations are not going to be implemented in accordance with original agreements.

HON. BOB STUMP TO VETERANS' ADMINISTRATION

QUESTION 1: What distribution is made of your Semiannual Reports?

ANSWER: The Semiannual Reports are distributed to:

a. Administrator, Veterans Administration (VA)
b. President of the Senate, Speaker of the House, Chairman and ranking members of Congressional veterans, appropriations, government operations, and budget committees
c. VA field station directors and Central Office management officials
d. President's Council on Integrity and Efficiency (PCIE) Members
e. Veteran Service Organizations

In addition, copies of the report are available to the public. Those who have requested the report include the news media, libraries and scholars.

QUESTION 2: To what extent do your auditors involve themselves in rating decisions on claims for compensation or pension?

ANSWER: Our audit methodology has been to identify vulnerabilities in the compensation and pension system and provide the Veterans Administration with recommended controls to eliminate or reduce the VA's exposure to risk. In this role we are not directly involved in the actual rating decision for either compensation or pension. We do provide the VA rating specialists with information such as employability, income and dependency that the veteran has failed to provide. Based on the information we have provided together with other information, VA has changed ratings.

QUESTION 3: In several of your reports you have mentioned that costs of VA nursing home contracts have exceeded Medicare or Medicaid contracts. Are VA contracts tied to these other contracts? Please elaborate on the reasons why VA contracts are sometimes more costly?

ANSWER: VA community nursing home contracts are indirectly tied to Medicare or Medicaid contracts. Department of Medicine and Surgery Manual M-1, Part I, Chapter 12 states that contracts for nursing home care should be negotiated at rates which reflect the current market value of nursing home care in the local community. The VA policy states that Medicaid per diem rates normally provide an index to prevailing community rates. Since Medicaid per diem rates do not include payment for such health care services as laboratory fees and prescription drugs, VA contracting officials are authorized to negotiate higher per diem rates for all-inclusive contracts that include payment for these extra services. This allows the contracting officer more latitude than pre-1982 guidance which provided that a factor of 10 to 15 percent be added to the Medicaid rate as a basis for negotiating all-inclusive contracts.

In our September 30, 1986 audit of Contract Rates for Community Nursing homes we recommended that VA medical centers: negotiate contracts using Medicaid rates plus a supplemental amount based on usage of services and supplies as determined by periodic reviews; periodically identify additional community

nursing homes to increase competition for VA contracts; and discontinue the practice of filling prescriptions for veterans placed in community nursing homes on all-inclusive contracts. The Acting Chief Medical Director and the Acting Director, Office of Procurement and Supply concurred with the report recommendations.

QUESTION 4: During your audits, do you ever get into the question of possible understaffing which might cause veteran claimants to be ill served by delays in the adjudicating of claims or in the processing of applications?

ANSWER: Our audits have generally not found understaffing which caused delays in adjudicating claims or processing applications. However, recently, we reported a finding at one Regional Office concerning the need to prevent and collect death case receivables. Regional Office management stated deficiencies were due to staff turnover and insufficient staff to process the workload. Our analysis supported this position and in response to our recommendations, the Regional Office Director increased staff in both the Adjudication and Finance Divisions.

QUESTION 5: With respect to your actions on mobile homes under the GI Bill, are you satisfied that the matter has been cleared up?

ANSWER: Investigations and prosecutions of mobile home manufacturers who are suspected of having falsely certified invoice prices submitted to the Va under the Mobile Home Loan Guaranty Program are continuing. Futhermore, our recommendations presented to the Department of Veterans Benefits (DVB) are still being analyzed to arrive at the necessary systemic changes to the mobile home loan guaranty program. Until the necessary implementing directives are issued and are put into action, we cannot consider this matter cleared up.

QUESTION 6: Some audits have indicated a finding that outpatient care may have been improperly given. Would you please comment on these kinds of findings?

ANSWER: Outpatient medical treatment for veterans with nonservice-connected (NSC) conditions is authorized when required to complete an episode of inpatient care; when prescribed by a physician to obviate the need for hospitalization; or, when provided as part of the patient's pre-bed care. Our audits of medical facility operations find some veterans receiving outpatient care who do not meet this criteria. For example, at one outpatient clinic, 7 percent of the outpatient visits reviewed were followup visits by veterans being treated for NSC conditions which did not need additional care to avoid hospitalization. At another facility, we found about 12 percent of the outpatient visits were for conditions which had stabilized and should no longer have been treated in the ambulatory care program. Findings such as these lead to recommendations to provide outpatient treatment only to veterans who are entitled to such care by governing laws and regulations.

QUESTION 7: On occasion your auditors suggest curtailment of various construction projects. It has been inferred that local management had already decided on such curtailment, but that the audit report took credit for it. Would you please comment?

ANSWER: Our audits generally do not recommend the deletion of a construction project if the facility management has formally taken action to remove the project from the plan. Evidence of such facility action would be (i) a request from the facility to either Regional or Central Office officials indicating the planned action and (ii) a concurrence on the part of the Region or Central Office. In those instances in which management has indicated that they have taken action pertaining to a construction project on which we are also reporting, it is because either the Region or Central Office has not taken action or agreed with the planned action. Our purpose in reporting is to add support to local facility management's decision and, if necessary, raise the issue to the next higher level of review. Our goal is to preclude the expenditure of funds on unnecessary construction.

QUESTION 8: What relationship exists, if any, between your office and the budget process in terms of translating projected savings into reduced budget requests?

ANSWER: There is no direct relationship between the potential cost efficiencies recommended by the OIG and the budget of the VA. However, the OIG reports are provided to VA managers and budget officials for their use in managing the VA programs. It is expected that the actions taken as a result of our recommendations, which affect operations, will in turn impact on the respective budget submissions by the managers of the VA programs and functions. Therefore, although the relationship between our recommended efficiencies and the VA budget is not direct, the results of many of our recommended actions are inherent to the VA budget submission.

QUESTION 9: How effective is the IG's Hotline?

ANSWER: The IG Hotline has been effective in helping the Office of Inspector General meet its mandated responsibilities of preventing and detecting fraud, waste and abuse. While the preventive aspects of the IG Hotline's work can not be easily quantified, the fact that it operates 24 hours a day, 7 days a week, follows up aggressively on allegations received, and achieves positive results from these follow ups, should help deter future abuses.

The IG Hotline has also been successful in helping detect fraud, waste and abuse in Agency programs and operations. For instance, during Fiscal Year (FY) 1987, the IG Hotline opened 551 cases and closed 503 cases. Of the cases closed, 28 percent contained allegations that were substantiated. These substantiated allegations resulted in 252 corrective actions (i.e. employee removals, reprimands, counselings, etc.) and cost recoveries and efficiencies totaling over $83,000.

The IG Hotline also receives numerous calls and letters from veterans and their families requesting assistance concerning their VA benefits, medical treatment, etc. The OIG attempts to assist all those who contact it. In FY 1987, over 3,000 such requests were referred to the appropriate program office for review and appropriate action. As a result, we have received many notes from veterans and their families expressing their gratitude for our assistance.